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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 1987

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

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PART 8

TESTIMONY OF MEMBERS OF CONGRESS AND OTHER INTERESTED INDIVIDUALS AND ORGANIZATIONS

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 1987

TUESDAY, MARCH 4, 1986.

TESTIMONY OF MEMBERS OF CONGRESS AND OTHER INTERESTED INDIVIDUALS AND ORGANIZATIONS

UNIVERSITY OF MASSACHUSETTS, AMHERST CAMPUS

WITNESS

STACEY ROTH, CO-PRESIDENT

Mr. NATCHER. Our first witness this morning is Ms. Stacey Roth.

Mr. CONTE. Thank you, Mr. Chairman.

At the outset I want to thank you for giving Stacey this opportunity. Stacey Roth is co-president of the University of Massachusetts, Amherst campus, the Amherst student government. The campus has 25,000 students Mr. Chairman, and it's no small feat to be elected to govern that large a constituency. It is like being mayor of a pretty good size city.

She is down here with a student group advocating for student financial aid. They are called SAFA. They have been in existence for six years, meeting with me and meeting with you, Mr. Chairman.

I want to thank you for your speaking to them yesterday, Mr. Chairman. They have been speaking to Congressmen and Senators educating them on student financial aid. Stacey, we are proud to have you here today.

Ms. ROTH. Thank you.

Mr. NATCHER. Go right ahead. We would be pleased to hear from you.

Before you proceed, I would like for all of you ladies and gentlemen that are from the University of Massachusetts to know that it is a distinct honor and privilege for me to serve on this Subcommittee with my friend, Silvio Conte. Mr. Conte is not only the ranking minority member on this Subcommittee, but on the full Committee on Appropriations.

And my friend, Carl Pursell, who sits on Silvio's right this morning will tell you that when we take this bill to the floor of the House, Silvio Conte is right there with us at all times.

We will be glad to hear from you.

Ms. ROTH. Thank you. Mr. Chairman, the honorable members of the Committee on Appropriations, Subcommittee on Labor, Health and Human Services, and Education, I am Stacey Roth. And I am honored to speak before you this morning both as a member of students advocating financial aid and also as the elected representative of 18,300 undergraduate students at the University of Massachusetts at Amherst.

I would like to thank you for your sincere efforts surrounding this year's budget proposals. I would like to present our major concerns regarding the proposed cuts in financial aid awards under the deficit reduction acts.

As a representative of SAFA, I would like to thank Chairman Natcher for speaking with our group yesterday and allowing us to present our concerns of these extremely valuable financial aid programs and our concern that they remain intact, thus providing the wonderful opportunity for the youth of today to share the glory of higher education.

The University of Massachusetts has long prided itself upon its commitment toward being an institution of diverse composition. This diversity is a result of high accessibility. There are a large percentage of students who receive financial aid, which is again preserved through concentrated efforts toward maintaining reasonable tuition and fees as well as providing important financial aid packages.

At U Mass alone we process some type of financial aid for approximately 18,000 graduate and undergraduate students. Based upon the proposed FY-87 budget our University would stand to lose between 4,000 and 5,000 students that are currently receiving financial aid.

We find this unacceptable and dangerous toward the future of an educated America. To further substantiate this is the linear reduction of Pell which is based on our current shortfall. We propose that this Appropriations Committee fund the shortfall and provide Pell Grant supplemental program to cover the losses this fall.

Our institutions of higher education in America and the financial aid programs which Federal and State Governments have been able to provide within them are invaluable to the future of America. Technology, education, liberal arts, whatever the case may be, they are all important in some way, shape, or form to the youth of today and to the elders of tomorrow. We ask you to fund the programs which make America live.

Thank you for hearing me this morning.

Mr. NATCHER. Thank you. And we want you to know that we appreciate your appearance before our Committee at this time. You made an excellent statement. We are glad to have you.

Mr. Conte, I yield to you.

Mr. CONTE. I want to compliment Stacey. This was on really short notice, Mr. Chairman, and she drew these remarks up just a few minutes ago. And I want to compliment her for the constructive presentation here. It was excellent.

Ms. ROTH. Thank you.

Mr. CONTE. We are going to do all we can to see that we fulfill the requisite numbers for Pell Grants and SEOGS.

I could not have a better Chairman than Bill Natcher. He is like my brother. Year after year they have tried to cut these programs, and we have stood together. We got the funds back in there, Bill. And we are going to try to do it again this year.

Mr. NATCHER. Thank you very much. We appreciate it.

FRIDAY, MARCH 14, 1986.

SOCIETY FOR ANIMAL PROTECTIVE LEGISLATION

WITNESS

CHRISTINE STEVENS

Mr. NATCHER. Our first witness this morning is Ms. Christine Stevens. Come around, Ms. Stevens. It is a pleasure to have you before the committee again, and we will be pleased to hear from you.

Ms. STEVENS. Thank you, Mr. Chairman. I am delighted to be here, and particularly because of your wonderful statement, which made such a great difference with respect to the primates at the University of Pennsylvania.

We really appreciate your taking the leadership that you did, and it is going to have a beneficial effect on the treatment of laboratory animals throughout the entire United States, so we can't possibly thank you enough for what you have done.

As you know, the University refused for many months to admit that anything was wrong, despite the evidence of gross abuses well known to the Congress. Chairman Natcher's excellent statements clearly played a major role in bringing about acknowledgment of wrongdoing.

The principal investigator listed in the National Institutes of Health grants book, Dr. Thomas W. Langfitt, and Dr. Thomas Gennarelli, who ran the laboratory, have been reprimanded by the University. The baboon experiments are no longer being conducted, and funds are not available for them from the National Institutes of Health.

We also wish to commend the National Institutes of Health for similar actions with respect to the City of Hope and Columbia University Medical School. In the case of the University of Pennsylvania and the City of Hope, NIH reacted to revelations of abuse and neglect of laboratory animals exposed by animal rights activists and accompanied by extensive publicity in the media.

In the case of Columbia University, however, NIH took the initiative in a commendable fashion with regard to suspension of funds. The U.S. Department of Agriculture's veterinary inspectors had found serious deficiencies in the course of their inspections under the Federal Animal Welfare Act, and these findings were made known to NIH under the memorandum of understanding among USDA, NIH and FDA.

Photographs were also taken by an activist group, but publicity in the media occurred only after NIH made an unannounced inspection.

This is an example of how government supervision of animal experimentation should work. USDA veterinarians observed deficiencies and put the institution on notice that they had to be corrected.

NIH corroborated USDA's findings and suspended grants using large animals. USDA is continuing to monitor the animals, because although no experiments are now being conducted on them, many of them are being maintained under conditions which still require correction.

The new amendments to the Federal Animal Welfare Act, "Improved Standards for Laboratory Animals," provide that USDA veterinary inspectors examine Institutional Animal Committee inspection records and forward any which include reports of uncorrected deficiencies and deviations to "any funding Federal agency of the project with respect to which such uncorrected deficiencies and deviations occurred."

There is a further provision which I won't read.

The valuable work of the Department of Agriculture in administering the Animal Welfare Act must continue. The National Institutes of Health is not and does not wish to be a regulatory agency. It needs the input from USDA on the actual conditions in the registered research facilities, large numbers of which receive NIH grants.

Although not within the direct jurisdiction of this subcommittee, it is vital that you know that the entire program has been zero-budgeted by the Office of Management and Budget for the second year in a row.

It is essential that this program continue without interruption. Scientific groups and animal protective groups are in full agreement on the importance of the program, which requires a minimum of $6.55 million for fiscal year 1987.

This is something that animal protective groups and scientific societies are in full agreement.

I would like to submit a copy of the recently published Animal Welfare Institute book, "Beyond the Laboratory Door," for reference by this subcommittee. Divided in three parts, it begins with quotations from USDA veterinary inspectors' reports, continues with photographs, and concludes with excerpts from scientific journals.

An appendix indicates the level of funding by the National Institutes of Health and relates this to the degree of compliance with the minimum standards of the Animal Welfare Act. Institutions receiving such funding should eliminate excessive use of animals and maintain minimum standards for their welfare at all times.

This subcommittee can exert a powerful influence for good by continuing the interest it demonstrated so effectively last year. Perhaps this subcommittee could cut through difficulties surrounding the 15 monkeys which belong at NIH after the grant for their use by Dr. Taub was terminated.

They have not been released to a primate retirement facility. These monkeys are not being used for research, and it is expensive for NIH to house them.

At a time when the government is seeking to economize in every way possible, the current expenditure should and can readily be eliminated by sending the monkeys to an establishment such as Primarily Primates.

Again, thank you for the wonderful progress which you have brought about.

Mr. Natcher. Ms. Stevens, thank you very much. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Ms. Stevens follows:]

SOCIETY FOR ANIMAL PROTECTIVE LEGISLATION
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Funding for Care and Housing of Experimental Animals

Care and housing of experimental animals constitutes only a very small part of the cost of medical research, but failure to maintain minimum standards for animals can result in erroneous data, misleading findings or completely ruined projects. We have an obligation to the animals that give their lives for human benefit. It is important that humane requirements be observed for the sake of those animals. It is necessary, too, in order to prevent waste of government funds.

Grants from the National Institutes of Health do not, as a general rule, include funds for animal care and housing. The basic assumption, with which we agree, is that the institution should be prepared to properly maintain any animals designated for research. However, if an NIH panel decides that certain animals are to be used in a particular proposal, funds for appropriate housing and care, where needed, should not be arbitrarily withheld.

The attached manual, *Comfortable Quarters for Laboratory Animals*, gives examples of appropriate housing for experimental animals. Copies are provided free on request to scientific institutions by our companion organization, the Animal Welfare Institute. As the illustrations show, it is the immediate surroundings of the animal which should receive attention. Expensive construction of large buildings is not necessary, and we most emphatically do not advocate the provision of millions of dollars by NIH to erect structures such as those which are, regrettably, too popular at present in which windowless rooms, often underground, are used for every species regardless of the differing behavioral needs of the animals.

The windowless rooms in these big costly new buildings are filled with cages, generally of minimal size, and no further thought is given to the animals' environment. There is nothing inexpensive about this unpleasant accommodation. As Senator John Melcher stated about an empty chimpanzee cage he observed: "it was extremely efficient, extremely expensive and extremely cruel." He described it on the Senate floor as "about the size of a shower stall." The provision in the 1985 amendments of the Animal Welfare Act for "a physical environment adequate to promote the psychological well-being of primates" is Senator Melcher's.

It would be entirely appropriate for NIH grants for research using primates to provide funds for such an environment, and we wish to recommend that this distinguished subcommittee so inform NIH.

Animal experiments should be conducted only in institutions capable of providing care and housing suitable for the species used. If an institution cannot afford to maintain large numbers of animals properly, it should restrict itself to smaller numbers of those species it is capable of housing or to alternative systems not requiring animals.

Where NIH approves a grant to any institution which does not have appropriate care and housing for the animals involved, NIH should either 1) provide the necessary funding for animal care and housing, or 2) withhold the grant until such provision is made from another source.

FRIDAY, MARCH 14, 1986.

THE HUMANE SOCIETY OF THE UNITED STATES

WITNESS

DR. JOHN E. McARDLE, DIRECTOR, LABORATORY ANIMAL WELFARE

Mr. NATCHER. Our next witness is Dr. McArdle. Come around, Doctor, we will be pleased to hear from you at this time.

Mr. McARDLE. Mr. Chairman, I would like to second Mrs. Stevens' thanks for your leadership role in dealing with the animal situation.

Over the last several years, I have appeared before this committee to express the concern of the Humane Society of the United States, and the need to develop alternative methods for animal research.

There have been several recent developments, in particular the passage of the recent amendments to the Animal Welfare Act, in which what was observed at the beginning was the importance for the continuing need to develop alternatives.

And the conference committee report identified the need to develop additional alternatives. In particular, the Office of Technology Assessment released its report on alternatives to the use of animals in research testing, and education, and I was a member of the Technical Advisory Panel to that report, and it acknowledged the continuing use of animals in research, but it made it clear there was a need to develop new methods.

NIH, through its Division of Research Resources, has now set aside a separate section whose mission is to look into areas of research, to identify the needs of these areas. We would like to request, when that study is done, NIH specifically prepare a document identifying which areas are most amenable to the development of alternatives.

We would hope that that document could act as the basis for funding requests, and along the lines that NASA uses in its program, set out the goals and ask for grants to be submitted with proposals to meet those particular needs.

We have been told by NIH in recent conversations, if they have the money, they would like to earmark specific funds for the development of alternatives.

We would like to request, as we had last year, that the General Accounting Office do an analysis of the Regional Primate Research Centers Program, and we believe from our following of that program that there are still serious problems with the quality of research and the care of the animals in those facilities and such a study could act as the basis for identifying which facilities could be closed, and the money saved could then be used to redirect it for the development of new alternative technology, and change facilities to centers for the development of alternatives.

The third area that is of concern to us, the use of pets in biomedical research, a continuing problem. Last year, I was active with groups in 15 States to fight this, and we have been able to stop it in several localities.

In your own State of Kentucky last month, legislation was introduced to ban pound seizures in the State of Kentucky. We would ask the committee consider putting an amendment on the appropriations bill to prohibit the use of any Federal funds for the purchase or use animals, either acquired directly or indirectly from an animal shelter.

Mr. **Natcher**. Thank you, Dr. McArdle.

[The statement of Mr. McArdle follows:]

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Testimony Prepared for

The House Representatives

Committee on Appropriations

and

Subcommittee on Labor-Health and Human

Services-Education

Presented by

The Humane Society of the United States

Dr. John E. McArdle

Director

Laboratory Animal Welfare

March 14, 1986

MR. CHAIRMAN, I am Dr. John McArdle, Director of Laboratory Animal Welfare for The Humane Society of the United States (HSUS) and a research scientist with over eight years experience using nonhuman primates and other laboratory animals in biomedical research. I am pleased to have this opportunity to speak to you on behalf of The HSUS and our more than 450,000 constituents. I have three specific proposals to present to this committee.

Introduction

For several years we have testified before this committee, requesting that the federal government direct funds for the development and promotion of new alternative technologies, specifically designed to replace or reduce the numbers of animals currently being used in biomedical research.

With the recent passage of amendments to the Federal Animal Welfare Act and release of the Office of Technology Assessment analysis of alternatives to the use of animals in research, testing and education, we believe now is the time for a positive response from the agency primarily responsible for such research, i.e., the National Institutes of Health.

The opening section of the recent amendments to the Animal Welfare Act state:

> Methods of testing that do not use animals are being and continue to be developed which are faster, less expensive, and more accurate than traditional animal experiments for some purposes and further opportunities exist for the development of these methods of testing;

In addition, according to the Conference report, the intent of Congress is that "the adequacy of efforts to develop techniques that reduce or eliminate the use of animals be a matter of continuing concern and attention." This concern is more comprehensively discussed in the final OTA report. Although acknowledging the contributions traditional animal research methods have made which are beneficial to human health, the OTA also stresses the progress being made in replacing many whole-animal methods. The OTA study documents the diverse alternatives currently available and opportunities for future development of methods that are both scientifically and fiscally more sound than traditional experimentation.

Among the options the OTA offered for the consideration of Congress were:

1. Require a new or existing Federal entity to coordinate the validation and implementation of alternatives.

2. Provide intramural and extramural Federal funding for the development of alternatives.

Proposal 1: Development of New Alternative Technologies

The principal objective of the Division of Research Resources (NIH) (DRR) is the creation and development of new resources for the biomedical research community. We recommend that this Committee, through a modest redirection of existing funds, encourage the DRR to pursue that goal by changing its current perspective and begin to actively encourage the replacement of traditional methods of biomedical research with alternative technologies. Although there will always be some areas of research that require intact laboratory animals, insufficient emphasis has been placed on biomedical education and Federal funding for either the utilization of existing or the development of entirely new alternative methods. The principal factor restricting a broader adoption of alternatives is the recalcitrant resistant attitude of the biomedical research community. Intellectual tradition, rather than necessity, and a lack of commitment by the appropriate Federal granting agencies to developing new methods encourages the continued excessive use of laboratory animals.

Although some alternative techniques currently in use were developed as "by products" of other research projects, this has not always been, nor need not continue to be, the accepted approach to advancing biomedical research. If funds were specifically directed to developing alternatives, individual scientists would apply for and subsequently produce the new methods needed to improve the quality and reliability of biomedical research. The HSUS urges this subcommittee to encourage development of alternatives by appropriating sufficient funding to undertake more exploration.

The work of professor Joseph Leighton, Medical College of Pennsylvania, clearly illustrates how this process would work. In the past few years millions of rabbits have been used in the Draize test by having corrosive and irritating substances placed in their eyes. Results of this test are ambiguous and provide little protection for the American consumer, while causing extreme suffering in the rabbits. Since 1911, it has been known that the choriallantoic membrance of chicken eggs, an intact circulatory system lined with cells similar to those on the cornea of the eye, has an inflammatory response to irritants. Professor Leighton was the first to realize that the chicken egg was a potential alternative to the rabbit. Once provided by animal welfare organizations with sufficient funds, he was able to develop this approach and is now clearly demonstrating responses to irritants equal to or superior to those previously observed in rabbit eyes. As is typical of alternative techniques, the egg tests are highly reliable, faster and significantly less expensive. The use of laboratory animals requires caretakers, animal facilities, cages, food, bedding, veterinary care and often considerable cost to purchase the animals from commercial breeders or dealers. Any time an alternative replaces a significant number of animals, there will be substantial savings of research funds, which are already in short supply.

The NIH, through a newly created subdivision of the DRR, is currently assessing the current usage and future needs of animal models. This process includes consideration of those areas in which more appropriate alternatives could be developed. In a recent conversation with NIH officials, we were told that they would actively promote research into the development of alternatives, if funding could be found to support such goal-oriented research.

We request that the Committee instruct NIH to prepare a document indicating, 1) which areas of research are most amenable to the use of alternatives, and 2) which new techniques are needed to meet those needs. Such a document could serve as the basis of specific requests from NIH for research proposals to develop new alternatives. The grant solicitation process used by NASA could serve as a model for use by NIH. In its solicitation process, NASA identifies problems it wishes to explore and asks for grant proposals specific to that framework. This process would seem to lend itself to an alternatives program at NIH, as well.

We believe adequate funding to support such research can be found by closing one or more of the Regional Primate Research Centers and using the money saved to convert the closed facilities into National Centers for the Development of Alternatives.

Proposal 2: General Accounting Office analysis of the Research and Husbandry Programs of the Regional Primates Research Centers.

Rather than continuing or automatically increasing funding for the seven Regional Primate Research Centers (RPRCs), we believe a detailed study by the General Accounting Office (GAO) is long overdue. Such an analysis would, we believe, confirm our contention that the PRCs are characterized by poor quality research, inadequate care of their animals and a waste of already scarce biomedical research funds. Such an accounting could act as the basis for selecting which facilities would be closed.

The RPRCs were established to "ensure that the special environments required for biomedical studies with primates are available to U.S. scientists." They were designed to serve as national resources for the U.S. biomedical research community, but they have consistently failed to achieve that goal. A British government study in 1969 was the first to note that the RPRCs' visiting scientist programs were "surprisingly small" and "do not provide a service outside their own organizaton." They summarized the RPRC program noting "the quality and quantity of work emerging from the NIH-sponsored programs does not appear to justify the great expense incurred" and that a similar RPRC program in England "would not be in the best interest of the majority as it would tend to attract available funds to the minority." Additional DRR-commissioned reviews of the RPRC program in 1976 and 1979 noted that these observations were still appropriate. In fact, the situation had actually deteriorated with regard to the quality of the research programs and the care of laboratory animals. Our ongoing, comprehensive examination of the RPRC annual reports since 1979 clearly shows no improvement in research programs or animal husbandry.

The RPRCs are still proposing and conducting research that duplicates work being done elsewhere or already-known projects for which viable alternatives are available, projects using inappropriate animal models or projects which serve no useful scientific purpose. For over twenty years, the RPRCs have failed to perform as originally intended. Several hundred million dollars have been wasted to support such cruel and scientifically unjustifiable projects as toxicity testing of substances already in long-term use or previously banned substances, and an unending series of permutations of experimental psychology protocols.

Proposal 3: Protecting Pets from Use in Biomedical Research and Education.

In the past, we have requested that this subcommittee include a provision to specifically state that no federal money could be used for the purchase or use of any cat or dog acquired directly or indirectly from a municipal or private shelter (i.e., to stop pound seizure). We are still seeking such a provision as the only possible mechanism to prevent people's pets from being used in biomedical research. In addition, we see the theft of pets for use in biomedical research and the problems with Class B animal dealers as directly correlated with the continuation of pound seizure. The continued use of random-source animals, such as those from pounds and shelters, in research, testing, and education encourages and continues the theft of pets. Theft of dogs and cats (directly or by fraud) for sale to research is increasing nationwide. We have documented the actions of dealers (bunchers) and representatives of research institutions, when they come to the pounds and shelters. They do not select the sick, injured, aggressive, maladjusted, feral dogs and cats. They take the friendly, healthy, socialized, trusting animals.

Precisely those animals guaranteed to be pets are the most likely to be lost and waiting to be reunited with their family or adopted by a new family.

With regard to claims that an absence of pound animals will seriously hinder biomedical research, please consider the following:

1. Of the 10 states with largest volume of animals used in research, four (including the top three) ban pound seizure.

2. Of the four states with the largest volume of dogs used in research, three ban pound seizure.

3. Of the 10 states with the largest number of registered research facilities, four of the top six ban pound seizure.

4. Pound seizure is banned in nine states and three foreign countries, all of which are engaged in major biomedical research projects.

5. The World Health Organization and Council of Europe both recommend against the use of pound animals.

6. NIH bans the use of pound animals in their own extension research programs and has done so for nearly 10 years.

There are now fundamentally five issues involved here:

1. Pounds and shelters are founded and operated as sanctuaries, not as warehouses to supply subsidized products for biomedical research.

2. The public loses confidence in local shelters and animal control agencies and stops cooperating with their programs.

3. Continued perception of pounds as a cheap and inexhaustible resource, inhibits the development of more appropriate alternatives.

4. Pets continue to be stolen for resale to research institutions. This will not stop until the use of random-source animals ceases.

5. Carefully controlled studies have proven that pound animals are unsuitable for use in biomedical research.

We are now convinced that the only viable, guaranteed means to stop the theft and use of pets in research, is to ban the use of such random-source animals. It is time to return the pounds and shelters to their proper status as sanctuaries which address the serious problems of responsible pet ownership, pet protection and animal control. We are again seeking your assistance in accomplishing that goal.

Finally, The HSUS wishes to thank members of this subcommittee who joined with their congressional colleagues in urging that the head trauma laboratories at the University of Pennsylvania be closed. Last summer, NIH announced the indefinite suspension of funding for these cruel projects which had been criticized by many notable researchers, as well as by animal welfare organizations. We thank you for your concern and help in ending this abuse of animals, as well as taxpayers' dollars.

Mr. Natcher. I want all of you who testify to know that we appreciate your coming and talking with us. Mr. Conte and I have the responsibility of taking this bill to the Floor and passing it. We believe this is the most important appropriations bill that we have, and we can prove it, Doctor.

This is the main appropriations bill. We have 13 of them. This bill has had a rocky road down through the years. Two years ago, Mr. Conte and I passed this bill in an hour and 53 minutes.

We talk to you people, and hear from you and it helps us. A lot of times, we don't get all the information we want until we hear from the outside witnesses, and we appreciate your coming.

Mr. McArdle. It is a pleasure to be here.

Mr. Natcher. Thank you very much.

Friday, March 14, 1986.

COMMITTEE FOR HUMANE LEGISLATION, FRIENDS OF ANIMALS, INC.

WITNESS

HOLLY HAZARD, COUNSEL

Mr. Natcher. Our next witness is Holly Hazard.

Ms. Hazard. I am Holly Hazard, Attorney with the Committee for Humane Legislation. Our concern regarding the appropriations for the National Institutes of Health is the tremendous waste of Federal funds in grant awards approved by NIH.

I recognize the importance of research programs as an investment in our future. I also recognize the important role that NIH has played in this investment in its first 100 years of operation.

Through those 100 years, science has changed dramatically. Unfortunately, many research projects have not. Our government is currently funding millions of dollars in medical research which is unlikely to lead to an improvement in the human condition.

Funding of these projects wastes increasingly precious research dollars, detracts from alternative projects, and unnecessarily wastes millions of animal lives.

Because of our limited time, I will concentrate my remarks on the misuse of Federal funds in the area of behavioral and psychological research, although a review of the grant abstracts currently funded shows Federal dollars being wasted throughout the Federal grant system.

In the area of behavioral research, many protocols currently funded involve research using humans. Given the cultural, sexual and environmental factors which contribute to radically different behavioral patterns within our own species, these projects would seem to hold the most promise for addressing and solving human problems.

However, many studies use other animal species to offer guidance in dealing with human behavior. Many of the abstracts of funded research are farcical in their attempt to correlate the findings to our own species.

Although scientists argue of their need for freedom in scientific pursuits whenever these protocols are questioned, no rationale exists for the Federal Government to fund these projects when they are not in the best interest of the taxpayer.

Under the guise of psychological research, animals have been shocked to investigate the causes of human cooperation, fear, pain and aggression. They have been forced to swim until they sink to investigate human stress, separated from their mothers and peers to investigate depression, and force-fed alcohol to determine the causes of human alcoholism.

The recently released Office of Technology Assessment Report on alternatives to animal use states, with reference to electric shock experiments, that "electric shock is a highly atypical stimulus. No terrestrial species appears to have evolved under conditions of electric shock."

In reference to aggression studies as an indication of factors affecting human aggression, the OTA report concludes that "extrapolation among vertebrates of the results of research into aggression is difficult." Despite these concerns as to the value of this research, Federal funding continues.

As an example of the specific projects in question, the latest available reports on Federal funding of research shows that NIH spent approximately $896,000 on "aggression" studies on mammals in fiscal year 1986.

This is obviously a small fraction of total funding for psychological research programs. Of this amount, only $126,000 was allocated to projects which directly evaluated any human behavior. All the projects used some animals.

The $770,000 spent on animal research includes, one, a study of aggression and sexual behavior in the female hamster. Grant award: $60,537.

Two, a study of anxiety and aggression in rats. Funded for 12 years. Grant award: $76,850.

Three, a study of whether the position of a male mouse in his mother will later affect the likelihood of him committing infanticide and why the timing of mating affects the likelihood of male mice committing infanticide. Funded for two years. Grant award: $30,254.

These types of studies have been carried out for decades. I have attached a random selection of studies published in this area in the past two decades to provide you with a background of typical research in this area.

Perhaps, given unlimited resources and no ethical concerns, these experiments could be justified. However, our society is an ethical one and we certainly are faced with finite resources. Given these parameters, continued Federal funding of these experiments cannot be justified.

The NIH has coordinated and funded many invaluable projects in its 100 years of operation. These projects should not, however, be allowed to justify the gross waste of research dollars in research which is unlikely to result in any improvement of the human condition.

Animal research in the area of behavioral and psychological studies has not provided the American taxpayer with any significant return on his investment. I urge this committee to stop Federal support of these wasteful and redundant projects.

Thank you very much.

Mr. NATCHER. Thank you very much, Ms. Hazard. You have made an excellent statement. We appreciate your appearance before the committee.

[The attachments to Ms. Hazard's statement follow:]

Aggression Research on Animals

Behavioral research on animals receives a great deal of federal support from the National Institutes of Health. The NIH budget has alloted 2.9 billion dollars for research in the areas of life and other sciences including psychology and social sciences for FY 1987. Of this, a substantial portion will be used in psychological research on animals. These experiments are redundant and wasteful of increasingly precious research dollars. They not only cause needless suffering to the animals involved but retard the process of worthwhile scientific exploration in areas likely to improve the human condition.

A sampling of experiments published in the recent past in the area of aggression research shows:

1985

1. Rhesus monkeys, which were isolated from all social contact during the first 9 months of life, and given electric shocks, are more likely to exhibit aggressive behavior in the form of self-injurious behavior than other monkeys. Journal of Abnormal Psychology, 94:2 222-226.

1984

1. More male mice having cohabitated with intact female mice display intraspecific fighting behavior after castration than male having cohabitated with ovariectomized mice. Aggressive Behavior, Vol 10, p. 317-324.

1983

1. The fact that female gerbils are lactating does not influence the likelihood of aggressive behavior after repeated aggressive experience with unfamiliar male intruders. Physiology and Behavior, 30: 319-321.

1982

1. Cohabitation with a male mouse, and not pregnancy may suppress aggression in lactating female mice. Behavioral and Neural Biology, 36: 242-58.

2. Electric shock is similar but not as potent as defeat in reducing aggression in mice. Psychological Reports, 51: 52-54.

3. Killer rats which are starved or shocked are not any more or less likely to attack mice, whether they are allowed to eat their prey or not. Animal Learning and Behavior, 10: 141-144.

1981

1. When a female is present in a cage containing a more aggressive or dominant male and a less aggressive or subordinate male, the former mate more frequently. Journal of Comparative and Physiological Psychology, 95: 880-895.

2. Mouse aggression increases after 24 hours of isolation or housing with females. Behavioral and Neural Biology, 32: 89-103.

1973

1. Comparisions of feeding behavior in killer and non-killer rats shows that although mouse-killing rats do tend to eat their victims, the killing motivation can be separated. Journal of Comparative and Physiological Phychology, 84, 258-264.

1972

1. Although mouse-killing rats do tend to eat their victims following a kill, there is no evidence that the act of killing, per se, increases the likelihood or strength of subsequent eating. Journal of Comparative and Physiological Psychology, 84, 258-264.

1962

1. Animals which are shocked, elict outwardly directed aggressive behavior or shock reflexive fighting. Journal of the Experimental Analysis of Behavior, 6:511-520.

The previous experiments were selected out of published articles in scientific journals relating to phychological experiments. These specific experiments may or may not have been directly funded by the federal government and are shown only as examples of the types of experiments being conducted an animals to explore aggression.

The following research protocols have been selected for federal funding through 1986 in the area of aggression research:

Crisp Report File

1. Using mice, rats and squirrel monkeys, researchers investigate the role of social status as a determinant of alcohol's effect on aggressive behavior, the effect of self administration versus forced administration of alcohol on social behavior, and the effect of testosterone on the aggression-heightening effect of alcohol.
   Years funded--5
   Award amount, 1985--$149,391
2. Evaluate the effect of alcohol on aggression in rats including female attack on males and fear based attack by both males and females.
   Years funded--2
   Award amount, 1985-- $73,619
3. The study of the sociosexual behavior of the female hamster.
   Years funded--1
   Award Amount, 1985-- $60,537
4. Regulation of infanticide and patental behavior in male house mice. The effect of intrauterine position on later behavior as a parent mouse toward their young.
   Years funded--2
   Award Amount, 1985-- $30,254

FRIDAY, MARCH 14, 1986.

PEOPLE FOR THE ETHICAL TREATMENT OF ANIMALS

WITNESS

ALEX PACHECO, CHAIRMAN

Mr. NATCHER. Our next witness is Mr. Alex Pacheco. Come around, Mr. Pacheco, we will be pleased to hear from you at this time.

Mr. PACHECO. Good morning, Mr. Chairman.

I would like to thank you for the opportunity to testify. I am Chairman of an animal rights organization, with a national membership of about 120,000, and I am here to thank you this morning about the abuse of two things, the abuse of animals and their suffering, and about the abuse of money that is appropriated from this subcommittee to the National Institutes of Health.

Five years ago, I testified before Congressman Walgren's subcommittee concerning animal abuse at an NIH-funded laboratory. NIH's response was that they had no reason to believe there was anything wrong at all. It took a lot of work, but finally that abusive laboratory was closed down.

Last year, I testified before you about animal abuse at another NIH-funded facility, the Head Injury Laboratory at the University of Pennsylvania. NIH again said they had no reason to believe anything was wrong, describing the laboratory as "one of the best in the world." After a year and a half of fighting NIH and a lot of support from yourself and other Members of Congress, this laboratory too was finally shut down.

Today, I bring to your attention another case of animal suffering which is also a case of wasting Federal dollars.

I bring this to your attention to point out once again that animals continue to suffer in Federally-funded facilities and because I believe the situation I will describe reveals NIH's casual attitude toward its budget and the treatment of animals.

Today's case began in 1981, when I conducted an undercover investigation of IBR, the Institute for Behavioral Research, an NIH-funded laboratory eight miles from here in Silver Spring, Maryland.

Violations of Federal and State anti-cruelty laws were obvious, and using a search and seizure warrant, police discovered 13 dead primates and confiscated 17 surviving primates.

IBR's chief animal experimenter, Edward Taub, was arrested for cruelty to animals and the primates were sent, under court order, to the NIH facility in Poolesville, Maryland.

In 1981, I, along with others, filed a class action civil suit to prevent these abused animals from being returned to their abusers to be crippled and killed as intended. The suit is still pending.

Today, almost five years later, all of the criminal trails and appeals are over, IBR's funding has been revoked, the laboratory is closed down, and Edward Taub has left IBR. Almost everything is over, except the suffering of the animals.

Those animals that were seized by the police are still suffering today, and for the last five years, they have been caged at the Poolesville facility.

Under the Freedom of Information Act, I have obtained a copy of a letter dated September 4, 1985, from the laboratory to NIH, in which the laboratory states that they have no use for the animals, that they do not even want the animals, and that they are hereby releasing "to NIH any and all rights which it may have to the 15 primates."

I also have an October 2, 1985 response from NIH in which NIH says they "have no research protocols, either ongoing or planned, for which these animals are appropriate" and that they will not accept the animals.

Yet, NIH continues to spend our tax dollars to finance expensive civil litigation, fighting us in the courts, over animals they have no use for and do not even want. And that is not all.

According to NIH officials, NIH is spending over $30,000 over a year, well over $120,000 since 1981, just to cage these monkeys.

And all along, since 1981, NIH has known that humane organizations have offered, at no cost to the Federal Government, to move these animals to a primate sanctuary in Texas and provide lifelong care for them.

These primates, who were originally purchased at taxpayer expense in 1979, for an experiment long discontinued, need to be transferred to a sanctuary. NIH is failing to act in the best interest of the taxpayers and the animals.

It has chosen instead to spend Federal dollars on costly caging and litigation for animals they have no use for, in an effort to "beat" the humane community. We believe the situation is explosive and that as long as NIH finds it desirable and acceptable to deliberately separate itself from the humane community and citizen watchdog groups for animal protection, problems will continue to surface in unpleasant ways, as with the University of Pennsylvania and the City of Hope.

Meanwhile, 15 highly intelligent, normally social primates remain isolated and deprived, like warehoused goods. Day after day, year after year, these animals languish in a windowless, cylinder block room, staring out of their barren steel cages.

NIH has taken no action to change the status of a living animal from a disposable "item." NIH contends it has no authority to reclaim animals purchased with NIH grants, even when the experimenter is convicted of cruelty and fraud, and even when the experiment is discontinued and the animals are abandoned.

They maintain that even though they have paid for the whole kittencaboodle, they have no authority to reclaim these animals.

This case demonstrates how animals like these are just left to rot in Federally-funded laboratories. It also demonstrates NIH's casual attitude toward dealing with animal suffering and the Federal dollars used to finance it.

We all know that NIH is always loath to do something it has never done before. It is now faced with a long-standing problem that can be resolved immediately. NIH must be compelled to act, for the monkeys and for the taxpayers. I urge you to see to it that they do.

Thank you, Mr. Chairman.

Mr. NATCHER. Thank you, Mr. Pacheco. We appreciate your appearance. You made a good statement.

[The statement of Mr. Pacheco follows:]

Oral Testimony by

Alex Pacheco, Chairman
People for the Ethical Treatment of Animals, Inc.

Submitted to

House Appropriations Subcommittee
Labor, Health and Human Services, and Education

March 14, 1986

People for the Ethical Treatment of Animals
P O Box 42516 Washington D C 20015 202-726-015

THE I.B.R./"SILVER SPRING MONKEYS"

THE PROBLEM:

A colony of monkeys, removed in 1981 from a Maryland laboratory under a historic search and seizure warrant, are suffering in a wholly unnecessary legal battle -- at taxpayers' expense.

According to NIH officials, NIH is spending over $30,000.00 tax dollars a year -- over $120,000 since 1981 -- to house the primates at its Poolesville facility. This does not include medical care and treatment or the cost of significant litigation.

IBR, the business from which the animals were removed by police, has written privately to NIH stating that it does not want the surviving primates (The primates were surgically crippled by IBR under a grant from NIH). IBR's animal laboratory has now been closed for several years and it has not used animals since IBR's chief experimenter was convicted of cruelty in 1981. IBR's grant has been permanently revoked on the grounds that IBR was guilty of failing to properly care for the animals.

NIH has stated that it does not want the primates either. These animals were originally purchased through NIH with taxpayers' money.

Yet NIH, which could act today to move the primates to a sanctuary, continues to spend taxpayers' money on legal expenses, in an effort to "save face" by keeping humane organizations from acquiring protective custody of the animals.

THE SOLUTION:

Both NIH and IBR have known since 1981 that a non-profit primate sanctuary, Primarily Primates, Inc., in San Antonio, Texas, is willing and able to provide permanent homes for the animals for the rest of their lives, at no cost to taxpayers, NIH or IBR. Since 1981, PETA has offered to cover all costs of transferring the primates.

While NIH and IBR fight to maintain custody of animals they have no use for and no professed interest in, these 15 highly intelligent primates remain permanently confined in solitary steel cages at NIH. Members of humane groups are only allowed to visit them every two to three months. NIH and IBR choose to ignore the solution which is in the best interest of the taxpayers and the primates.

* Insititute for Behavioral Research, now named Insititutes for Behavior Resources.

ANIMAL LEGAL DEFENSE FUND-WASHINGTON, D.C.
Box 4066
Rockville, Maryland 20850

BACKGROUND ON THE IBR PROBLEM

1965 Fire kills all primates and other animals at IBR. Dead primates found chained to metal poles in laboratory.

1977 Maryland State Humane Officer complains to USDA of extremely unsanitary conditions at IBR. One week later, USDA veterinary inspector visits IBR and reports:

> "Floors were dirty and bloodstained with feces all over them. These cages had not been cleaned in over a week"

USDA discovers that although federally funded for seven years, IBR never registered the facility as required by federal law. No action taken.

An NIH inspection reveals five major deficiencies at IBR. No action taken.

1979 IBR's principal experimenter, Edward Taub's grant application to NIH is denied due to the death of 80-90% of the animals at IBR, among other reasons.

A second grant application for $300,000 and 30 primates is approved by NIH.

1981 PETA conducts undercover investigation of IBR.

September: Based on affidavits from five scientists who witnessed conditions at IBR, police execute a search warrant and confiscate 17 surviving primates of an original group of 30. Two barrels of dead monkeys found in the feed room cannot be legally seized. Taub is arrested and charged with 17 counts of cruelty to animals; one for each of the live monkeys found at IBR.

October: Despite strong objections by consulting primatologists, the police, the State's attorney's office, veterinarians, and humane officers, a county judge rules the 17 monkeys are "property" and must be returned to IBR. Four days after the monkeys' return, IBR reports that one monkey, Charlie, has died from a heart attack. Before the body is given to police for autopsy, Charlie's heart, lungs, kidneys, and other vital organs are removed and destroyed, making it impossible for police to determine the actual cause of death.

NIH suspends IBR's grant based on an inspection of IBR ten days after the police raid. NIH cites five major deficiencies, almost identical to those found in 1977.

Formerly Attorneys For Animal Rights-Washington, D.C.

1981 IBR's hand-picked veterinarian resigns, calling IBR "unsuitable" for the primates.

A judge orders the monkeys removed again from IBR and transferred to the NIH facility in Poolesville, MD. NIH begins paying over $30,000 per year to cage the primates. NIH veterinarians discover that one primate, Nero, is in danger of dying from chronic bone infections and proceed to amputate an arm. Another monkey, Hard Times, becomes paralyzed due to faulty surgery performed at IBR in 1979. Because he is in severe pain, he is killed by injection.

November: IBR's chief animal experimenter, Taub, is convicted of cruelty to animals on six counts, corresponding to the six primates that were most seriously injured at the time they were confiscated from IBR by police. IBR announces its intention to finish his experiments by crippling the monkeys' healthy arms and then killing all the animals two weeks later.

December: PETA, the International Primate Protection League, and private citizens file a precedent-seeking class action civil suit in the Montgomery County circuit court, requesting protective custody for the animals.

1982 PETA continues the fight for custody of the monkeys in the civil courts.

1983 Taub, previously convicted of cruelty to animals in two criminal trials, appeals his conviction. The Maryland Court of Appeals reverses the guilty findings on the grounds that animal experimenters funded with federal tax dollars are not required to obey state anti-cruelty laws.

IBR's animal experimentation facility is shut down.

1984 IBR loses its second appeal to regain its NIH research grant.

1985 September: IBR attempts to "release to NIH any and all rights which it may have to the fifteen primates now under NIH care."

November: NIH rejects IBR's attempt to relinquish control of the primates to NIH.

1986 PETA continues to fight in the civil courts for custody of the 15 remaining primates.

IBR
INSTITUTES FOR BEHAVIOR RESOURCES, INC

Institute for Behavioral Research
Institute for Social Services

September 24, 1985

Dr. William F. Raub
Associate Director
Office of Extramural Research & Training
National Institutes of Health
9000 Rockville Pike
Building 1, Room 107
Bethesda, MD 20205

Dear Dr. Raub:

At a recent meeting of the Board of Trustees of the Institutes for Behavior Resources, Inc., it was resolved that IBR relinquish ownership to NIH of the fifteen primates presently under NIH care.

The trustees took this action because the primates do not fit into the present IBR program. The Trustees objective is to relinquish ownership of the primates without publicity.

We have recently been informed by Dr. Edward Taub that although the application to complete his research was favorably reviewed, the priority rating in peer review renders the probability of funding remote. Consequently, in the absence of such funding, Dr. Taub will not continue to pursue this research effort, and will not require further use of the primates.

It, therefore, appears that NIH is the sole entity in a position to determine what use or disposition of the primates should be made in public interest.

Accordingly, IBR, as sponsor of the research project, releases to NIH any and all rights which it may have to the fifteen primates now under NIH care.

Sincerely yours,

Joseph Vasapoli

Joseph Vasapoli
Chief Executive Officer

cc: Dr. Joseph V. Brady, Acting Chairman of IBR's Board
Dr. Edward Taub
Edgar H. Brenner, Esquire
James Miller, Esquire

A NON-PROFIT INDEPENDENT EDUCATIONAL, SOCIAL SERVICE AND SCIENTIFIC ORGANIZATION WITH MAIN OFFICE AT
6527 Chillum Place, N.W., Washington, D.C. 20012
Phone 202/722-1701

Edu Folo-1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

October 2, 1985

Mr. Joseph Vasapoli
Chief Executive Officer
Institutes for Behavior Resources, Inc.
6527 Chillum Place, N.W.
Washington, DC 20012

Dear Mr. Vasapoli:

I am responding to your letter of September 24 regarding the IBR monkeys housed at the NIH animal facility in Poolesville, Maryland. The NIH does not accept the proposal that we take ownership of them. We have no research protocols, either ongoing or planned, for which these animals are appropriate.

As various NIH spokespersons have indicated from time to time, we wish to discontinue our temporary custody of the IBR monkeys as soon as possible. We are prepared to release the animals immediately to an IBR official or an IBR designee. Please let me know how you wish to proceed. I will be available for discussion if you would find that helpful.

Sincerely yours,

S/

William F. Raub, Ph.D.
Deputy Director for Extramural
Research and Training

bcc:
Dr. Malone
Dr. Goldstein
Dr. Whitney
Mr. Lanman

NIH:OD:OERT:WFRaub:le 10/2/85
Official File located in NIH/OD Files

OD Files

FILE
COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE

ANIMAL LEGAL DEFENSE FUND-WASHINGTON, D.C.
Box [illegible]
Rockville, Maryland 20850

March 4, 1986

Congressman Rod Chandler
216 Cannon House Office Building
House of Representatives
Washington, D.C. 20515

Re: Fifteen monkeys in the custody of the National Institutes of Health

Dear Congressman Chandler:

I would like to describe a conversation Alex Pacheco and I had with Dr. William Raub, Associate Director, Office of Extramural Research and Training, National Institutes of Health. We had wanted to speak to him in our continuing efforts to acquire the fifteen surviving monkeys originally seized by the Montgomery County Police Department from the Institute for Behavioral Research (IBR) on Septemeber 11, 1981. We had reason to believe that we were close to our goal because IBR had, by letter dated September 24, 1985, relinquished all right, title, and interest in the monkeys to NIH.

Mr. Pacheco and I had originally scheduled a meeting with Dr. Raub at his office on October 9, 1985. Shortly before we were to leave for the meeting, Dr. Raub's secretary telephoned to inform us that we could not meet with Dr. Raub that day but that a telephone conversation could be arranged.

My notes of the telephone conversation between Mr. Pacheco, Dr. Raub, and myself reflect the following:

1. Mr. Pacheco indicated we were still persuing our goal of placing the fifteen monkeys in a sanctuary for primates in Texas and that we knew of IBR's relinquishment of its right, title, and interest in the monkeys;

2. Dr. Raub indicated that the monkeys were not NIH property but that NIH would assist IBR in disposing of the monkeys;

3. Dr. Raub then stated that IBR's relinquishment was a unilateral gesture that was not acceptable to NIH;

4. Dr. Raub went on to say that, while NIH had good reason to facilitate a transfer of the monkeys, NIH would not intervene to counsel IBR to negotiate;

5. Dr. Raub concluded by promising NIH technical and logistical support in any future transfer of the monkeys.

NIH had the opportunity to resolve this long standing controversy as to a permanent placement for the fifteen monkeys and to ease the federal taxpayers' burden of housing, feeding, and caring for these monkeys. I understand the cost of this is in excess of thirty thousand dollars per year. There is no rational reason why Dr. Raub failed to take advantage of IBR's offer, and thereby permit the placement of these monkeys in a humane sanctuary.

I hope you can get to the bottom of this.

Sincerely,

Roger Galvin
Attorney At Law

December 7, 1981

Edward Taub, PhD
Institute for Behavioral Research
Silver Spring, Md.

Dr Taub:

My name is Wally Swett. Greg Miller, Ken Oberg and I have founded Primarily Primates, a refuge for homeless animals. Our ranch has the status of a public charity and is legally dedicated to its present use. It is located some 15 miles northwest of San Antonio, Texas in the relative isolation of the Texas hill country. We are extremely fortunate in having excellent facilities for the care and maintenance of our charges. For example, we have two excellent wells which assure us an unlimited water supply, stone house and outbuildings for shelter, outstanding veterinarians, well-established trees and shrubbery for shade and privacy, etc. Greg, Ken, and I have been providing for homeless animals for years although Primarily Primates has only recently found its permanent location (Summer, 1981).

We do not support any specific animal rights or animal welfare organizations although we have the approval and support of The Simian Society of America and the International Primate Protection League.

We have followed your - may I say, "dilemma?" - closely since your primates were seized on September 11, 1981. We have been unable, however, to determine the court's view of ownership and eventual custody of the 16 monkeys. In light of the widespread publicity this case has received, it has occurred to us that both IBR and NIH will be further criticized by media sympathetic to your accusers if the primates are returned to the laboratory or, perhaps especially, if they are euthanized, even if such euthanasia is performed for scientific purposes. To be perfectly frank, Dr Taub, no matter what the outcome of your appeal, your conviction in the Maryland District Court essentially invalidates any data you may gain in the future from these specific subjects.

Primarily Primates is dedicated to the lifelong care and comfort of animals such as your 16 monkeys. We have carefully and thoroughly considered the special problems of a deafferented primate and have concluded that such problems are manageable with the resources available to us. We have long dealt with large and sometimes intractible primates (usually pets) from homes which have not provided for their dietary, veterinary, and/or physical requirements and have had remarkable success in the elimination of problematic medical and behavioral symptoms.

To the point, Dr Taub, we offer you an alternative, one which may gain you some much-needed favorable press and, at the very least, will serve to prevent public criticism of your future treatment of these animals. We offer a lifelong home for the monkeys; a home we believe to be the best available anywhere. We would, of course, prefer to receive the monkeys free gratis as shipping costs will, in themselves, prove expensive. We realize, however, that IBR is a private corporation which may not be in a position to simply give away these monkeys. We are therefore prepared to consider paying a reasonable sum to IBR for the animals. Please advise at your earliest convenience.

Sincerely,

Wally Swett

Primarily Primates
26099 Dull Knife Trail
San Antonio, Tx. 78229
(512) 755 4616

Copies to: Dr Robt. Whitney, NIH
Dr Joseph Vasapoli, IBR
Dr Thomas Malone, NIH

People for the Ethical Treatment of Animals
P.O. Box 42516, Washington D.C. 20015 202-726-015

October 11, 1985

James R. Miller, Esquire
Miller and Steinberg
414 Hungerford Drive
Rockville, Maryland 20850

Re: I.B.R. Monkeys

Dear Mr. Miller:

Per your telephone conversation with Roger Galvin, please be advised that People for the Ethical Treatment of Animals (PETA) hereby offers to assume all right, title and interest in the fifteen non-human primates now held at the N.I.H. Poolesville facility. PETA's intention is to place the monkeys permanently at Primarily Primates, Inc., a primate refuge located near San Antonio, Texas.

Dr. William F. Raub, Associate Director, Office of Extramural Research and Training, N.I.H., has agreed to facilitate this proposed transfer and has preliminarily agreed to provide technical support to effect the monkeys transfer. Dr. Raub is now actively exploring how N.I.H. can provide such assistance.

Our goal is simply and solely to provide a permanent home for these fifteen primates, not to engage in a media campaign. We have no desire whatsoever to be at odds in any way with I.B.R.. We are, in fact, prepared and willing to do whatever is necessary to make such a transfer as smooth and pleasant as possible.

We hope that you and your board will accept this proposal in good faith and agree to provide an opportunity for these animals to live out the rest of their lives in peace and tranquility. Please feel free to contact me at the above telephone number at any time or to contact Mr. Galvin at (301) 897-0896.

Sincerely,

Alex Pacheco
Chairperson

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
NATIONAL INSTITUTES OF HEALTH
BETHESDA, MARYLAND 20205

July 19, 1982

Mr. Steven M. Wise
2001 Beacon Street
Brighton, Massachusetts 02146

Dear Mr. Wise:

In May of this year, you asked for substantive information about the research of Dr. Edward Taub, especially regarding how it has contributed or might contribute to the improvement of human health. I regret that this response was delayed inadvertently but hope the following comments are helpful.

The monkeys operated on by Dr. Taub experienced a loss of sensory functions comparable to those experienced by certain stroke and accident victims; however, the monkeys' inherent ability to move is unimpaired. Dr. Taub's work indicates that the lack of purposive movement in these operated animals is mostly learned rather than the manifestation of any particular movement deficiency. If this information can be translated to the human clinical situation, it will have considerable implications for the early rehabilitation of stroke patients because it implies that these people can and should be treated to prevent this largely unconscious and involuntary "learned non-use."

As it now stands, it would be premature to apply the results of Dr. Taub's research in routine clinical use. His findings first would have to be verified by other investigators in long term experiments in other animals and then in a clinical research situation. To the extent that such further experimentation is pursued, good scientific practice dictates that the studies be designed in such a way that unnecessary use of animals is avoided while simultaneously ensuring that human patients are not exposed to inadequately tested procedures.

William F Raub
William F. Raub, Ph.D.
Associate Director for Extramural
Research and Training

FRIDAY, MARCH 14, 1986.

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

WITNESS

MICHAEL K. GEMMELL, EXECUTIVE DIRECTOR

Mr. NATCHER. Our next witness is Mr. Michael Gemmell. Come around, Mr. Gemmell, we are pleased to have you back before the committee again, and we will be pleased to hear from you.

Mr. GEMMELL. Thank you, Mr. Chairman, members of the subcommittee, I am Mike Gemmell, Executive Director of the Association of Schools of Public Health. The Deans of the 23 U.S. Schools of Public Health appreciate the opportunity to present our testimony on fiscal year 1987 appropriations.

We urge the subcommittee to continue Federal institutional support to these graduate schools of public health. You have been very supportive of them over the years. In fact, Congressional support for schools of public health began in 1956, making it the oldest Federal health professions education aid program in the country.

Since this Federal assistance program began, the number of accredited schools has doubled from 11 to 23, and enrollment has increased five-fold. Over 9,000 students are expected to enroll this September.

Yet, Mr. Chairman, there are still definite shortages of public health professionals today. According to the Department of Health and Human Services, there are insufficient public health personnel prepared to cope with all the demands to be placed on them in the coming decade.

Nationally, there appears to be critical shortage of epidemiologists, health statisticians, and certain types of environmental health specialists. The lack of non-infectious diseases and behavioral epidemiologists, public health nurses, toxicologists, risk assessment specialists in the chemical and physical agent arenas, health care finance specialists, and biostatisticians are most often cited by HHS.

A severe shortage of physicians exists throughout the field of public health. In epidemiology, a lack of physicians is particularly acute, and it is anticipated that strong demand for non-physician epidemiologists with doctoral training will continue as long as this shortage exists.

In environmental health, areas related to toxic substances, hazardous waste management, occupational safety and health, environmental epidemiology, and water treatment will experience the greatest shortage of adequately trained personnel to meet the needs of both public and private sectors.

In health administration, specialists in finance and economics will continue in high demand.

In other fields, public health personnel growth will be slow to minimal.

Schools of public health are currently experiencing another major crisis caused by a decreasing trend in the number of physicians entering academic public health. The dearth of professional staff in the field of public health and preventive medicine has been documented in report after report, ranging from studies by the Graduate Medical Education National Advisory Committee to those of the National Academy of Sciences.

In notable critical supply as physicians trained in preventive medicine, epidemiology, biostatistics and toxicology.

Mr. Chairman, I have attached to our testimony a document outlining these shortages in greater detail. With your permission, I would like to have it included in the record.

Given this shortfall in public health professionals, the Administration proposes to end this year academic public health capitation, traineeships and support for preventive medicine residencies, as well as support for CDC's prevention centers and AOA's health promotion projects, by requesting the rescission of fiscal year 1986 funds and requesting no funds for these programs in fiscal year 1987.

Since there is a short supply of public health personnel in our Nation and preventing disease is more cost-effective than curing it, it is supporting and confusing for the Administration to propose ending Federal support to schools of public health.

Given the present state of the deficit, certain reductions in Federal spending are justified. However, to recommend cuts in programs that contribute to keeping individuals out of the costly medical care system does not make sense.

Cost savings in the health care system can be achieved through greater emphasis on prevention, on programs that keep people and communities healthy.

Based on the fact that public health personnel shortages exist, we believe that continued Federal support is justified. Federal support is also justified on the grounds that graduates of the schools of public health work primarily in the public sector in the areas of health promotion and disease prevention, and, unlike graduates of other schools of the health professions, do not enjoy lucrative incomes; mean income of the 1981 graduates was $24,500.

They represent the basic resource pool from which Federal, State and local health and environmental agencies draw their manpower needs. Graduates also work and teach in university settings and industry relies heavily on the schools to train their employees involved in industrial hygiene and occupational safety and health.

Finally, Mr. Chairman, Federal support is justified because these schools of public health train professionals that will prevent disease and promote health. I have attached a letter from our President, Dr. William Bridgers, to you that highlights some of the major contributions of the schools of public health to disease prevention in this country.

Thank you, Mr. Chairman, for allowing us the opportunity to present our views. We respectfully urge that Congress approve our requests for PHS programs of primary concern to the schools of public health.

Thank you.

[The attachments to Mr. Gemmells statement follow:]

The Association of Schools of Public Health (ASPH) urges Congress to disapprove the Administration's request to rescind FY86 funds to Schools of Public Health and to approve the following amounts for FY87:

Appropriations (Millions)

	Final FY 1983	Final FY 1984	Final FY 1985	Final* FY 1986	Pres. FY1987 Requests	FY87 Author	ASPH Requests FY1987**
Institutional Support (Capitation)	$4.1	$5.0	$5.0	$5.0	0	$5.0	$5.0
Traineeships	$2.5	$2.5	$3.0	$3.0	0	$3.0	$3.0
Preventive Medicine Residencies	$1.0	$1.5	$1.6	$1.6	0	$1.6	$1.0
Centers for Health Promotion and Disease Prevention (CDC)	--	--	--	$1.5	0	$13.0	$5.0
Older Americans Health Promotion and Disease Prevention Projects (AoA)	--	--	--	$1.0	0	$8.5	$3.0
Educational Resource Centers (NIOSH)	--	--	--	$8.7	0	--	$8.3

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* The Administration is proposing to rescind these funds this year.

** Figures take into account Gramm-Rudman reductions.

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Contact: Mike Gemmell

PUBLIC HEALTH MANPOWER SHORTAGES:
Personnel in Short Supply

The Federal Government's responsibilities and objectives in the field of health promotion and disease prevention warrant a continued high level of concern for manpower resources in public health. Adequately trained public health professionals, effectively utilized, are essential to progress in prevention of diseases and the identification and control of environmental health hazards, among other national priority health goals. Again, health professions schools can be expected to initiate or expand programs aimed at addressing these critical health needs.

Types of specialists for which need continues to exist include:

- epidemiologists knowledgeable about non-infectious disease, new-generation infectious disease, and environmental problems;
- environmental health professionals skilled in toxicology, assessment of risks related to hazardous chemical and physical agents, and other specialty areas;

- public health nurses, nutritionists, and health educators prepared to address problems of children, the aged and the disadvantaged.

-- Robert Graham, M.D.
Administrator
Health Resources and Services Administration
HHS
Testimony before the House Subcommittee on Health and the Environment
April 24, 1984*

The President's justification for requesting FY86 rescissions and FY87 termination of funds to support Schools of Public Health is based on a series of false assumptions. First, federal health professions education policy has focused almost exclusively on hands-on physicians and their supply and OMB has based policy decisions affecting _other_ health professionals on conclusions relating to these physicians. For example, HHS studies have shown that there will be an oversupply of physicians around 1990. Based on this finding, the President zeros-out support for public health professionals that are undersupply. Available evidence indicates an _undersupply_ of public health personnel exists.

In 1979, the Surgeon General released his report, _Healthy People_, which said that although there is a lack of hard public health manpower data, there are definite shortages of certain specialized disciplines such as epidemiologists, biostatisticians, occupational and environmental health workers and health services administrators and managers. The majority of these professionals in great demand are trained in the 23 graduate U.S. _Schools of Public Health_.** The reasons for the lack of data are several, such as the lack of uniform and fixed definitions of public health jobs and requirements for employment, methodological problems and high costs of gathering information.

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*Same observations were made by Edward Brandt, M.D., Assistant Secretary for Health, HHS, before the Senate Committee on Labor and Human Resources, March 14, 1984.

** University of Alabama at Birmingham, Boston University, University of California-Berkeley, UCLA, Columbia University, Harvard University, University of Hawaii, University of Illinois at Chicago, Johns Hopkins University, Loma Linda University, University of Massachusetts, University of Michigan, University of Minnesota, University of North Carolina, University of Oklahoma, University of Pittsburgh, University of Puerto Rico, San Diego State University, University of South Carolina, University of South Florida, University of Texas, Tulane University, University of Washington, Yale University.

A December 1979 HHS report to Congress on community and public health personnel also called for increased federal support to programs training professionals in these priority public health areas. Furthermore, both the Institute of Medicine ("A Manpower Policy for Primary Care") and the HHS Graduate Medical Educational National Advisory Committee (report of September 1980) made a number of recommendations relating to increased federal support for public health and preventative medicine training programs because there are definite shortages in these specialized fields. (See Attachment A).

Both the 1980 and 1982 HHS reports to Congress on health professions reported that there are shortages of qualified public health professionals, especially environmental health specialists (toxicologists), epidemiologists, biostatisticians, public health physicians and nurses, among others. A 1980 HHS study of nutrition personnel in state health agencies reported significant vacancy slots for nutritionists.

The HHS Bureau of Health Professions (BHPr) reports that there is a shortage of faculty and researchers with expertise in a number of high-priority subject areas including chronic-disease, behavioral, and environmental epidemiology and environmental toxicology, including risk assessment of chemical and physical agents. Also in short supply among university faculties are public health nutritionists, occupational health specialists, and analytical scientists such as mathematical statisticians, biostatisticians, and computer specialists.

A 1985 BHPr draft report to Congress states that there exists a severe shortage of physicians throughout the field of public health. In epidemiology, a lack of physicians is particularly acute, and it is anticipated that a strong demand for nonphysician epidemiologists with doctoral training will continue as long as this shortage exists. In environmental health, areas related to toxic substances, hazardous waste management, occupational safety and health, environmental epidemiology, and water treatment will experience the greatest shortage of adequately trained personnel to meet the needs of both public and private sectors. In health administration, specialists in finance and economics will continue in high demand.

Schools of public health are currently experiencing another major crisis caused by a decreasing trend in the number of physicians entering academic public health. The dearth of professional staff in the field of public health and preventive medicine has been documented in report after report ranging from studies by the graduate medical education national advisory committee to those of the national academy of sciences. In notable critical supply are physician educators trained in preventive medicine, epidemiology, biostatistics, and toxicology.

In addition, the inability of Schools of Public Health to effectively compete with the corporate arena for the modest supply of non-physician graduates in environmental toxicology, non-infectious disease and behavioral epidemiology and health care finance, creates serious problems for the Schools (and federal, state and local health agencies) in their efforts to meet present public health problems. This brain drain will accelerate as more and more environmental hazards are being brought to the public's attention.

Furthermore, many health science students are not choosing careers in public health because of the 60 percent cutback in traineeships since 1981 and the high costs of taking out HEAL loans. Physicians, engineers, nurses, chemists and physical scientists are not entering the field in adequate numbers. In engineering, the small but continuous flow of engineering graduates that entered public health through the mid-1970's has all but ceased. In veterinary medicine, recruitment of veterinarians into public health has decreased. While graduates training in many specialty areas of nursing has grown dramatically over the past 10 years, the increase in nurses trained in public health at the graduate level has not kept pace. In fact, state health officers are very alarmed about the low number of nurses entering public health.

Given these shortages, the Administration proposes to end this year academic public health capitation, traineeships and preventive medicine residencies, as well as support for CDC's Prevention Centers and AoA's health promotion projects, by requesting the rescission of FY86 funds and requesting no funds for these programs in FY87.

Since there is a short supply of public health personnel in our nation and preventing disease is more cost effective than curing it, it is surprising and confusing for the Administration to propose ending federal support to Schools of Public Health. Given the present state of the deficit, certain reductions in federal spending are justified. However, to recommend cuts in programs that contribute to keeping individuals out of the costly medical care system does not make sense. Cost savings in the health care system can be achieved through greater emphasis (not reductions) on programs that keep people and communities healthy.

Based on the above findings and observations, ASPH believes that continued federal support is justified. (See Attachment "B".) Federal support is also justified on the grounds that graduates of the Schools of Public Health work primarily in the public sector in the areas of health promotion and disease prevention and, unlike graduates of other schools of the health professions, do not enjoy lucrative incomes (mean income of 1981 graduates was $24,500). They represent the basic resource pool from which federal, state and local health and environmental agencies draw their manpower needs. Graduates also work and teach in university settings. Industry relies heavily on the Schools to train their employees involved in industrial hygiene, occupational safety and health, environmental toxicology, among others. The breakdown is as follows: 44 percent of graduates in a single given year go into federal, state or local government service, 30 percent work for either non-profit community health agencies or universities and 22 percent work in the propietary sector.

Finally, federal support is needed to help the Schools in their efforts to train professionals that will prevent disease and promote health. The Surgeon General of the United States recently said "Further improvements in the health of the American people can and will be achieved--not through increased medical care and greater health expenditures--but through a renewed national commitment to efforts designed to prevent disease and to promote health" (Healthy People).

The Nation's Schools of Public Health

Schools of Public Health have been educating professionals in the techniques of health preservation and disease prevention and control since the early decades of the twentieth century. Some Schools of Public Health had their beginnings in university schools of medicine; others were conceived from the outset as autonomous units within their parent institutions. There are twenty-three accredited Schools of Public Health in the United States - eight at private and fifteen at public universities.

The Schools are located in seventeen states and Puerto Rico and train students from every state in the nation. With a faculty of over 2,000, graduate education is offered to a combined enrollment of approximately 9,000 students in such specialized areas as biostatistics, epidemiology, environmental and occupational health, health administration, health planning, nutrition, maternal and child health and social behavioral sciences, among others.

Attachment "A"

1990 REQUIREMENTS FOR PUBLIC HEALTH AND PREVENTIVE MEDICINE

Manpower estimated by GMENAC

On September 23, 1980, the HHS Graduate Medical Education National Advisory Committee (GMENAC) met in Washington and adopted final recommendations (shown below) regarding the needed number of public health physicians for each specialty for 1990.

Present Supply	Aerospace Medicine	Occupational Medicine	Public Health and General Preventive Medicine	Total
Board-certified(1)	783	704	2,317	3,804
Self-identified(2)				
Administration	165	541	1,555	2,261
Research	27	28	204	258
Teaching	7	9	115	131
Patient Care	368	(1,695)*	(1,018)*	368
Other	17	78	147	242
	584	656	2,048	3,288

1990 Requirements for Board-Qualified Full Time Equivalents (3)				
Program Activities	250	1,400	2,100	3,750
Research	150	200	400	750
Teaching	60	300	450	810
Clinical Services	500	400**	400**	1,300
Other	0	0	200	200
	960	2,300	3,550	6,810

The estimate of total requirements as calculated above is 6,500-7,500

Shortage				
Number	376	1,644	1,502	3,522
Percent	64	251	73	107

*These are felt to be physicians providing regular clinical services though in a preventive medicine setting. The 2700 physicians have not been included in the final figures because in the GMENAC methodology these physicians have been includ-d in the enumeration of generalist physicians.

**These are in addition to other physician specialists working in a preventive medicine setting but who are providing regular clinical services.

Attachment "B"

The Association of Schools of Public Health (ASPH) urges Congress to disapprove the Administration's request to rescind FY86 funds to Schools of Public Health and to approve the following amounts for FY87:

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Traineeships	$2.5	$2.5	$3.0	$3.0	0	$3.0	$3.0
Preventive Medicine Residencies	$1.0	$1.5	$1.6	$1.6	0	$1.6	$1.0
Centers for Health Promotion and Disease Prevention (CDC)	--	--	--	$1.5	0	$13.0	$5.0
Older Americans Health Promotion and Disease Prevention Projects (AoA)	--	--	--	$1.0	0	$8.5	$3.0
Educational Resource Centers (NIOSH)	--	--	--	$8.7	0	--	$8.3

---

* The Administration is proposing to rescind these funds this year.

** Figures take into account Gramm-Rudman reductions.

ASPH
ASSOCIATION OF
SCHOOLS OF
PUBLIC HEALTH

President
William F. Bridgers, M.D.
Dean, School of Public Health
University of Alabama—
Birmingham

Vice President
Joyce Lashof, M.D.
Dean, School of Public Health
University of California—Berkeley

Secretary-Treasurer
Jan A. J. Stolwijk, M.S., Ph.D.
Chairman, Department of
Epidemiology and Public Health
Yale University

Immediate Past President
Robert W. Day, M.D., M.P.H.,
Ph.D.
Dean Emeritus, School of Public
Health and Community
Medicine
University of Washington

Legislative Committee
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Dean, School of Hygiene and
Public Health
Johns Hopkins University

Education Committee
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Raymond Seltser, M.D., M.P.H.
Dean, Graduate School of Public
Health
University of Pittsburgh

CEPH Liaison Committee
Chairman
David Pearson, Ph.D., M.P.H.
Associate Dean, Department of
Epidemiology and Public Health
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Jerrold M. Michael, M.P.H., M.S.
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March 13, 1986

The Honorable William H. Natcher
Chairman
Subcommittee on Labor/HHS/Education
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Once again I am honored to ask for your continued support of academic public health programs, in general and for the 23 U.S. Schools of Public Health, in particular. The $25 million annual contribution by Congress is a small but fair share of the costs incurred by our 23 Schools to train over 9,000 graduate students each year (it costs approximately $10,000 per year to train one student). We feel that this support is justified because it helps Schools of Public Health train health professionals in critical supply such as epidemiologists, biostatisticians, public health nurses, toxicologists, among others, and that they contribute greatly to keeping people well and out of the costly medical care system.

The latter causes us to have an image problem, Mr. Chairman. I suspect that part of the problem for public health and for those engaged in academic pursuits of ways to prevent disease is that, if we're successful, frankly nothing much happens. It's boring to prevent, but exciting to intervene with high tech treatments. In public health we continually face a public that wants to know, "So what have you done for us lately?"

Mr. Chairman, let me describe to you what we have done and about the great contributions of faculty in the Schools of Public Health:

- Schools of Public Health have played a critical role in the complete eradication (for the only time in recorded history) of a major scourge: smallpox. The theoretical and practical capability is now at hand to replicate this feat for measles and poliomyelitis, given the resources and commitment required. Schools of Public Health are now playing a key role in urging that this be done.

- The mention of polio brings to mind that it was in a School of Public Health that the iron lung was developed, permitting many with the bulbar form of this terrible disease to be kept alive. Fortunately, the need for them was negated by the development of an effective means to protect children from this disease, and the lion's share of the critical discoveries paving the way for development of a vaccine were made in a School of Public Health.

- Going back nearer their beginnings, in the 1920's vitamin D was discovered in a School of Public Health, and it can be fairly stated that America was taught to be milk drinkers by these faculty. The general principles of nutritional (vitamin) deficiencies and their corrections by properly balanced diets can be traced to these early efforts. As a result, vitamin deficiency diseases today are rare to nonexistent in developed countries. Schools of Public Health remain hot spots for nutrition research, an area of inquiry still struggling for its place in the sun in schools of medicine.

- In the same early period the applications of statistical methods as analytical tools in the management of diseases in population was brought to maturity by faculty in a School of Public Health. Epidemiology also began its maturation then. These techniques apply not only to epidemics of infectious disease but are just as valuable and necessary for establishing, for example, the fact that seat belts save lives.

- The roles of Schools of Public Health in eradication of hookworm and other such infections and in devising strategies to deal with sexually transmitted diseases are wellknown. A more recent example is AIDS, where one of the acknowledged world-wide spokespersons addressing this new viral disease is a dean of a School of Public Health. Because an enlightened and compassionate public is presently the only means whereby the transmission of HTLV-III virus can be slowed, many Schools have begun to mount efforts to inform a nervous public about this, the most frightening threat to the public's health since the polio epidemics.

- Not as widely recognized is the pioneering work many years ago in a School of Public Health in establishing the field of industrial hygiene. Thousands of factory workers throughout the world literally owe their lives to this discipline and to the work of these professionals. The work of Schools of Public Health on water quality, hazardous waste, and air pollution has been at the cutting edge of newly recognized health hazards.

- Insights into how to prevent typhus, trachoma, malaria, and numerous other diseases prevalent in tropical regions have been an especially fruitful area of research within Schools of Public Health, with a large potential payoff in terms of improved health and socioeconomic status.

- One final excellent example of the power of the modern epidemiologic approach for understanding how to prevent disease will perhaps make an important point that the traditional medical school faculty often overlooks. I refer to the "cause" of lung cancer. Whereas the molecular basis for cancer still eludes the basic scientist, that cigarettes cause lung cancer has been just as firmly established through epidemiologic techniques as would be the case if the cause had been discovered in a test tube. That, indeed, is the message; while vitally important basic biomedical investigations into causes of diseases go forward and are to be encouraged, the applied methods of public health are of inestimable value in control and prevention of disease -- chronic, debilitating disease of modern man as well as infectious disease in developing regions of the world. In many cases, the preferred strategy for control is prevention, not treatment. Lung cancer is a case in point: there's no silver bullet for its treatment.

Based on the above findings and observations, we believe, Mr. Chairman, that continued federal support to Schools of Public Health is justified. I respectfully urge you and your colleagues to disapprove the Administration's request to rescind FY86 funds to Schools of Public Health and to approve the following amounts for FY87:

Appropriations (Millions)

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Older Americans Health Promotion and Disease Prevention Projects (AoA)	--	--	--	$1.0	0	$8.5	$3.0
Educational Resource Centers (NIOSH)	--	--	--	$8.7	0	--	$8.3

Thank you.

Sincerely,

William F. Bridgers, M.D.
President
Association of Schools of Public Health
and
Dean
University of Alabama at Birmingham
School of Public Health

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* The Administration is proposing to rescind these funds this year.
** Figures take into account Gramm-Rudman reductions.

Mr. **Natcher**. Mr. Gemmell, you represent your Association in an excellent manner, and I say that to you frankly. You have been around here a while, and you know what you are doing.

You made a good statement, and we appreciate your appearance.

Mr. **Gemmell**. Thank you, Mr. Chairman.

Friday, March 14, 1986.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.

WITNESS

FAYE WATTLETON, PRESIDENT

Mr. **Natcher**. Our next witness is Ms. Wattleton. Come around, Ms. Wattleton, and we will be pleased to hear from you at this time.

Ms. **Wattleton**. Thank you, Mr. Natcher.

I am Faye Wattleton, President of Planned Parenthood Federation of America, the Nation's oldest and largest voluntary family planning organization. It is always an honor to appear before this subcommittee, and particularly before you, Mr. Chairman, and you, Mr. Conte.

This subcommittee and its leadership has been unwavering in its support for the national family planning program, Title X of the Public Health Service Act, and we continue to be grateful for your long-standing support.

Title X is the backbone of the national family planning clinic network that provides medical and education services to low-income women and teenagers. It is one of relatively few public health programs to remain a categorical program.

The Congress has wisely resisted efforts to fold Title X into a block grant, which would blur its identity and inevitably result in diminished public funds for critical family planning services.

Title X is also the one Federal program that demonstrably serves to reduce the need for abortion. This Congress is pressured by those who oppose abortion to vote over and over each year on negative proposals pertaining to abortion.

Title X remains as one positive law that Congress has enacted that does something concrete to reduce unwanted pregnancies in the United States.

In estimates from one recent year alone, the national family planning program averted 800,000 unintended pregnancies, including 425,000 among teenagers. Had these pregnancies occurred, they would have produced an estimated 282,000 additional births and 433,000 more abortions in just one year.

A recent poll by the Lou Harris organization indicated that an overwhelming majority of Americans, 84 percent, consider teen pregnancy to be a major national problem.

Greater emphasis and availability of family planning to teenagers is one means of addressing that problem that Americans widely support, according to the Harris poll.

With your permission, Mr. Chairman, I will submit the Harris poll data for the record.

The primary focus of Title X is contraception, preventing unwanted pregnancies and helping families to regulate their childbearing. But in addition, it has served as a very positive program.

Title X clinics offer infertility diagnosis, health screening and treatment or referral for anemia, hypertension, cervical and breast cancer, sexually transmitted diseases, kidney dysfunction and diabetes.

Clinics such as those financed through Title X often are the first place women, and especially teenagers, receive medical care. Clearly, Federal investments in family planning services are prudent.

A recent report by the Center for Population Options last month set at $16.7 billion the 1985 cost to taxpayers of services required to respond to the needs of families begun by teen mothers.

In 1981, there were 9.5 million low-income women and five million teenagers at risk of unintended pregnancy. The organized clinic system reaches about 5 million women, 1.6 million of whom are teenagers. Title X continues to be the single largest source of funds for this network.

Unfortunately, continuing pressure for cuts in domestic spending have taken a toll on the Title X program. In fiscal year 1981, the Congress allocated $166 million for family planning.

Here we are, five years later, in the era of Gramm-Rudman-Hollings, with only $139 million for the program. These funds have resulted in restricted family planning services, and a lack of capacity to provide the services to those who need it most.

Human behavior and societal health aren't particularly sensitive to Congressional budget restraints. Unless the cuts stop and funds are restored, the costly problem of unwanted pregnancy is likely to threaten deficit reduction efforts through massive increases in health and welfare entitlement spending.

The savings alone for prevention of teenage pregnancy would more than cover the funds that we request at this time before the committee.

I want to say a word about contraceptive research because, like Title X, it represents a prudent investment which will ultimately reduce government costs.

Title X authorizes research in the reproductive sciences, and in contraceptive development and evaluation. But of the $105 million spent on "population research" by NICHD, less than 10 percent goes for contraceptive development.

The recent decision by G. D. Searle to cease U.S. sales of intrauterine devices will drastically curtail the choices Americans have to control fertility. Searle's problem, difficulty in obtaining product liability insurance, sends an ominous signal to any private company trying to develop better methods of contraception.

There are nearly 100 new contraceptives in various stages of development. But without greater Federal emphasis on contraceptive development, the loss of IUDs on the American market is sure to increase the rate of unplanned pregnancies and abortions.

We urge this committee to endorse a specific increase for contraceptive development and evaluation, through an earmark or committee report directives.

Last year, Mr. Chairman, right-wing groups that campaign against legal abortion launched an attack on Title X. That was not new, they have done so for many years. Members sought to attach a rider to the Title X appropriation that would have done great harm to the program.

The reaffirmation of support by this committee for balanced, non-directive pregnancy counseling under Title X was a wise response to that effort. We applaud your steadfastness and urge you to resist similar pressures if they emerge this year.

The simple fact is, Mr. Chairman, Title X works well. Only a shortage of funding restrains its effectiveness. If the spending levels in place at the time this Administration came into office had been maintained, adjusted for inflation, we would be discussing a $210 million Title X program, not the $139 million current funding level.

In conclusion, we understand the pressures upon you as you try to balance social needs against demands for more military spending. We urge you to fund the Title X program for fiscal year 1987 at the full level approved by the authorizing committee for this year, $147 million, with a supplemental fund of $20 million to boost contraceptive development.

In this year of focusing on cost-effective programs at a time when Americans have expressed a deep concern about unintended pregnancies, particularly among teenagers, we urge your continued support for Title X and for population research as one of the Nation's highest priorities.

Thank you.

[The statement of Ms. Wattleton follows:]

STATEMENT OF

FAYE WATTLETON

PRESIDENT

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.

BEFORE THE

SUBCOMMITTEE ON LABOR-HEALTH AND HUMAN SERVICES-EDUCATION

COMMITTEE ON APPROPRIATIONS

UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 14, 1986

INTRODUCTION

I am Faye Wattleton, President of the Planned Parenthood Federation of America (PPFA). I am appearing on behalf of the more than 17,000 volunteers and staff who run our 187 affiliates in 46 states and the District of Columbia, the 250,000 individuals who contribute to our organizations, and above all, the more than 3 million women and men who are served by our clinics each year. I want to thank you and this subcommittee for the opportunity to present our views on the need to strengthen the national family planning program and expand research in contraceptive technology.

As you know, Title X of the Public Health Service Act is the core of our national family planning clinic network that provides subsidized services to low-income women and teenagers. For the sixth year in a row, the administration is once again seeking Title X's repeal in favor of its embodiment in a primary care block grant to states. This would not only eliminate the only specific source of funding for family planning services but also would place family planning services in direct competition with other basic health services for an ever dwindling pot of federal money. We are confident that Congress will continue its long-standing, bipartisan commitment to family planning this year and reauthorize the Title X program basically in its current form.

Although we are aware of the budgetary pressures on this committee, we are requesting that you restore funding for Title X. We do so because Title X's record of accomplishment shows that an investment in this program results in tremendous savings in health care and social services costs that the government would be obliged to pay.

Irrespective of a final ruling on its legality, the Gramm-Rudman-Hollings budget law has changed the political landscape for some time to come. Congress has a choice: it can make the tough spending decisions, reallocating scarce federal dollars into those programs which have proven successful and cost effective, or it can abdicate this responsibility, allowing the budget ax to fall evenly on all programs, regardless of their ability to produce budgetary savings over the long run.

We urge the Congress and this committee to assume the responsibility entrusted to you by those you represent by investing in the Title X program - one federal program where a relatively small increase in spending this year can result in tremendous savings in health care and social services costs to the government for many years to come.

Similarly, we also urge you to increase support for population research, specifically authorized under Title X and Section 301 of the Public Health Service Act, and to place particular emphasis on research leading to the development of new contraceptive technology. Recent distressing developments make this an urgent matter.

Of 36 million American women who are seeking to avoid pregnancy, three million are using no contraception, and another three million are using the least effective methods. The most common reason cited for using no method is the fear of possible side effects. It is critical that further studies be pursued to identify and counteract the specific risk factors that do exist. At the same time, intensified research in the development of new and improved methods of contraception could greatly enhance our ability as a society to lower the staggering 55 percent incidence of unintended pregnancy that still exists in this country today.

FAMILY PLANNING SERVICES

Mr. Chairman, the Title X program prevents unintended pregnancies, reduces the need for abortion, and provides basic health services to a large group of medically underserved women. It is estimated that approximately 800,000 unintended pregnancies - 425,000 among teenagers - were averted in one year alone (1981) as a direct result of the national family planning program. Had these pregnancies occurred, there would have been an estimated 282,000 additional births and about 433,000 more abortions in that year alone.

Moreover, in addition to providing basic contraceptive services (including natural family planning) and infertility diagnosis, Title X clinics also offer health screening assessments and either simple treatments or referral for anemia, hypertension, cervical and breast cancer, sexually transmitted diseases, kidney dysfunction and diabetes. The Reagan administration has called family planning "a vital health care program for women in this country." Clinics such as those financed through Title X often are the first place women - and especially teenagers - receive formal medical care.

As I have already noted Mr. Chairman, these services are made available at a considerable cost-savings to the government. Each dollar invested in family planning yields a two-dollar savings in the next year alone in health and welfare costs associated with pregnancy and childbirth. For teenagers the ratio is even higher: the federal government saves three dollars for every federal dollar invested in family planning. A report by the Center for Population Research released last month set at $16.7 billion the 1985 cost to taxpayers of public services required to maintain families begun by teen mothers. Clearly, federal investments in voluntary contraceptive services are wise and prudent.

Despite the accomplishments of the Title X program, a tremendous number of women continue to go unserved. In 1981, there were 9.5 million poor women and five million teenagers at risk of unintended pregnancy. In 1983, the organized clinic system made family planning services available to 5 million women, 1.6 million of whom were teenagers and 80 percent of whom were low-income, i.e., below 150 percent of the poverty line. Title X continues to be the single largest source of funds for this network, comprising 34 percent of the total federal and state expenditures. Primarily through the help of Medicaid or other special arrangements, an additional 3.2 million women were able to obtain contraceptive services from private physicians. The rest were left without health care.

Unfortunately, the growing need for the contraceptive and basic reproductive health services provided by Title X has been met by a shrinking federal commitment of funds. In FY 1981, Title X was funded at $166 million. The effects of the 25 percent cut later that year and in FY 1982 were severe. Straining to avoid turning patients away, clinics around the country were forced to reduce the scope of their services, especially community outreach to "hard to serve" patients. They have found it difficult to maintain, much less expand, educational programs geared toward adolescents and their parents -- exactly the sorts of programs Congress wants from Title X, as recent congressional debates have demonstrated. A $16 million increase in FY 1984 and an additional $2.5 million for FY 1985 - brought Title X funding from $124 million in FY 1982 to $142.5 million in FY 1985. The level was frozen at $142.5 million in FY 1986.

The 4.3 percent reduction on March 1, and the prospect of cuts two or three times that size if Congress fails to make spending and revenue decisions consistent with its deficit reduction goals, clearly jeopardize the future of Title X. Neither individual and societal health, nor the social and economic consequences of unintended pregnancy and childbirth, have not been sensitive to Congressional budgetary exigencies. Accordingly, individual family planning clinics, hospital programs and others are searching, often in vain, for ways of adequately serving their patient population's needs.

Looking beyond the statistics and the proven record of accomplishment of Title X grantees, I believe the time has come to question the motives and the illogical proposals of those who oppose family planning. These attacks and calls to curtail or eliminate the delivery of family planning services come almost exclusively from organizations whose primary mission is to once again criminalize abortion. Is it possible that they don't realize that eliminating the Title X program would lead to an increase in abortions? That deterring teenagers from seeking contraceptives by imposing a parental consent or notification requirement would lead to still more pregnancies among teenagers and more abortions? That excluding medically responsible individuals and organizations from the Title X program or from contracting for delivery of family planning services at home or overseas will lead only to more abortions?

The lines have been drawn on the abortion debate in this country and in the Congress. And yet, some members of Congress, though still not enough, who vote consistently to limit abortion funding, are among the strongest supporters of family planning, obviously recognizing the need to curb unintended pregnancies and thereby reduce abortions.

At the same time, we thank and commend the members of this committee who, late last year, voted down a proposal that would have throttled the ability of Title X counselors to give their patients confronting an unintended pregnancy full information about all legal medical options. The defeat of Congressman Kemp's amendment, and the reaffirmation of support for balanced, non-directive medical counseling, was important to the survival of Title X -- and this committee made the right decision.

While divisions on the question of abortion persist, I submit to you that we must all work together in supporting the means to reduce the need for abortion, a personal decision that no one makes without careful consideration and few choose without some measure of sorrow.

RESEARCH

Title X currently authorizes research in the reproductive sciences, social and behavioral studies, contraceptive development and contraceptive evaluation. The National Institute of Child Health and Human Development (NICHD) administers all these areas of research, which together are presently funded at approximately $105 million. Perhaps part of the reason this area of study receives such a low priority at the National Institutes of Health (NIH) is that NIH is mainly disease-oriented, whereas research of this type mainly benefits healthy people. The irony, of course, is that the strides we are able to make as a society in this field directly touch the lives of virtually all Americans, not to mention the rest of the world, for which NIH is the major source of research and contraceptive technology and development. Similarly, much of what we know today about the tremendous health, social and economic costs of adolescent pregnancy - to the adolescents and their families as well as society as a whole - has been generated by work in the social and behavioral research component. It is extremely important that greater financial support is given to all research in human reproduction and population.

We are especially concerned, however, about contraceptive research, with less than 10 percent of the current $105 million spent on "population research" going for contraceptive development. The recent decision by G. D. Searle and Company to cease all U.S. sales of its intrauterine devices (IUDs) by itself will severely curtail the choices American women and men have had to control their fertility. The reason cited by Searle for withdrawing its IUDs from the market, their increasing difficulty in obtaining product liability insurance, sends ominous signals to any company, agency or researcher that is currently trying to develop better, safer methods of contraception. There are nearly 100 new varieties of contraceptives in various stages of development, including several at NICHD. Some companies even have products ready for field trials but cannot get the insurance so that testing may proceed. With half of the pregnancies in this country unintended, the narrowing of effective choices of contraception, along with the potential increase in unplanned pregnancies and abortions that likely will result from the loss of IUD's, constitutes a national tragedy.

There will probably never be a single perfect contraceptive, since individual circumstances change over a lifetime, as do family planning goals and attitudes. Yet in spite of the universal interest in better contraception, federal support for development of new or improved methods, as well as for the evaluation of the safety and effectiveness of current ones, has actually declined since FY 1981. Just four years ago, the Office of Technology Assessment (OTA) recommended that an additional $20 million annually in federal funding for contraceptive technology, noting that available research opportunities are only waiting to be exploited. Mr. Chairman, I would like to insert into the record two recent articles from Family Planning Perspectives, published by The Alan Guttmacher Institute, on these leads and the availability of funding for some of these leads, which should give you an excellent idea of how close we are to better contraception. This is not a field which needs a single, massive injection of funds - rather, slow, steady funding is required to bring some of these leads to fruition.

As you have recently heard from administration testimony, NICHD continues to make last year's proposed Contraceptive Development Initiative a priority. However, prior funding commitments may make that initiative less of a reality than planned. Mr. Chairman, we need new methods of contraception. And we need to reassure ourselves about the safety and efficacy of current ones. We applaud NICHD's efforts in this area. At the same time, we strongly urge you to endorse a specific increase for contraceptive development and evaluation, through an earmark or committee report directives.

SUMMARY AND RECOMMENDATIONS

The highest point reached in Title X funding was an appropriation of $166 million in 1981. (This figure was cut back by a rescission to $162 million, the actual amount by which the program was funded that year.) Accounting for inflationary increases alone, the current level of Title X funding should be approximately $210 million. Given the reality mandated by the largest peacetime deficit in history and the Gramm-Rudman-Hollings mandate, we support funding for FY 1987 at the highest possible amount, noting that the authorizing committee has approved a funding level of $147 million. This figure would merely restore funding for the program to levels attained well before 1980, not accounting for inflation. For the Center for Population Research, PPFA recommends a special supplementary fund of $20 million in order to boost the Contraceptive Development Initiative.

We thank the committee for its support in the past. In this year of focusing on cost-effective programs, we believe that continued support for Title X and for population research should be high priorities.

Mr. NATCHER. Thank you very much. You and others are very much concerned about this program, and it is a good program. The Administration wants to put the family planning money into the block grant?

Ms. WATTLETON. The Administration has made such proposals before.

Mr. NATCHER. On a number of occasions. Last year we enacted $142.5 million as a separate line item. Are you against the block grant proposal?

Ms. WATTLETON. We have opposed it, and we continue to oppose it. As I indicated, we believe that this would diffuse the efforts of family planning programs and would create a situation in which family planning would not be a high priority.

We should be expanding family planning to reach increasing numbers of people to prevent unintended pregnancies, particularly teenagers, and we believe a block grant would subvert that effort.

Mr. NATCHER. Thank you very much.

You made a good statement.

FRIDAY, MARCH 14, 1986.

AMERICAN LIFE LEAGUE, INC.

WITNESS

JUDIE BROWN, PRESIDENT

Mr. NATCHER. Our next witness is Mrs. Brown.

Mrs. BROWN. Mr. Chairman, members of the subcommittee, I am going to excerpt from my fully prepared testimony, which I will submit for the record.

I am about to testify against a program, Title X of the Public Health Service Act, which has never really been officially authorized by the Congress, and continues through the appropriations process to be authorized by virtue of its appropriation.

We question the validity of that action. There are four assumptions about birth control that seem to supply the support for Title X program.

We are told it prevents abortion, that it eliminates adverse outcomes from unwanted pregnancy, does not stimulate sexual activity, and improves reproductive health.

While these assumptions have been repeated before House and Senate authorization and appropriations committees, none has been documented by proponents.

Amazingly, in the absence of evidence, and in the face of a rising incidence of out-of-wedlock births, sexually transmitted diseases, and legal abortions, some of them facilitated under Title X by an accounting finesse, or the farce of Title X counseling and referral programs from grant recipients that are co-located with abortuaries, the Congress, since 1971, has provided more than $1.7 billion for the Title X birth control program alone.

Birth control proponents have long known from studies, some of them from Planned Parenthood, and from uncontested clinical experience, reaffirmed by Potts in 1981, that abortion is more frequent birth control users than among non-contraceptors.

In what must certainly be unique in the annals of legislation, the U.S. Congress is funding the demise of the American family under the family planning program.

This policy is the brain child of the largest single recipient of Title X funds, the Planned Parenthood Federation of America, an organization which has long shown an interest in manipulating or even breaking the law to further its own ends, in spite of Congressional statutes, as can be seen below.

First, law breaking: In the 1984 "The Human Right to Family Planning," authored by Faye Wattleton and six others, we find, "Family planning associations and other non-governmental organizations should not use the absence of law or the existence of an unfavorable law as an excuse for inaction; action outside the law, and even in violation of it, is part of the process of stimulating change."

Last year, when the question of prohibiting abortion counseling came up, Planned Parenthood and other population control groups draped themselves in the First Amendment as if it were their exclusive property.

The success of their effort, in my judgment, depended upon a general ignorance of what Planned Parenthood and its supporters meant by "abortion counseling." It is much more than keeping a list of physicians, so-called, and clinics where pre-born babies are put to death.

A quote from their guidelines reads, "Counselors must have knowledge regarding availability of insurance coverage or other reimbursements for abortion."

And further, referral fees and contracts: "A fee may be charged for counseling. Under some government contracts, however, the affiliate may bill the government funding agency on behalf of the patient and reimburse the abortion provider."

You have heard information about the Harris poll, at a sum cost to Planned Parenthood of $80,000; but you will not hear, I am certain, one of the fundings, when individuals were asked by the Harris poll questioners, "What do you think is the most important thing that parents should do to prevent their teenage children from becoming pregnant?", an astonishing 73 percent of those polled responded with other suggestions rather than birth control and abortion services for their children.

The publicity touting the alleges success of the school birth control clinics is another matter that must come to your attention.

A questionnaire prepared by the Center for Population Options, the single major proponent of the school birth control clinic emporium, asks students if they have ever thought of suicide, or if they ever made themselves vomit after a meal, ever felt life was not worth living, and what the source of parental income was, whether or not they had VD, and so forth.

Many of these questions are so personal, I will simply submit them for the record.

I ask you, would you as a grandparent or a father want some woman whom you did not know asking such personal questions of your children, Mr. Chairman?

I have six requests that I would like to make this morning.

One: Currently, HHS guidelines prohibit patient consent for permanent sterilization under age 21. In light of the possibility of pelvic inflammatory disease and the likelihood of permanent infertility from PID as a result of IUD or oral contraceptive use, shouldn't Congress consider a parental consent requirement before dispensing such drugs and devices in Federally-supported birth control clinics?

Two: As the physician package insert on oral contraceptives requires that a complete medical history, including family predisposition to cancer, be taken, shouldn't Congress inquire whether or not Title X grantees who do not interview parents for such information are fulfilling their Congressionally imposed responsibility under the Food and Drug laws?

Three: At present, Title X grantees are not required to screen for gonorrhea, except perhaps where an IUD is requested. Shouldn't Congress require gonorrhea screening of all individuals with more than one sexual associate in the previous six months?

Four: Because chlamydia appears to be an even greater problem than gonorrhea, shouldn't Congress require screening of women on the pill at least once every six months?

Five: Shouldn't Congress require a minimum age of 17 as a condition of eligibility for recipients of any birth control drug, device or chemical under Title X and other Federally-subsidized birth control?

Six: Shouldn't Congress require screening of additional sexually transmitted diseases, including AIDS, in Federal birth control programs.

I further ask that the record be kept open for 30 days of additional material the American Life League and others might wish to submit to the subcommittee pertinent to Title X, and for a full research document on the school-based clinical situation, which we have been unable to prepare due to the moving up of the date of this hearing, if you would consent to that?

Mr. NATCHER. We will take that up with the subcommittee, and we want to thank you for your statement. You made a good statement.

[The statement of Mrs. Brown follows:]

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March 14, 1986

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PRO-LIFE LEADER CHALLENGES CONGRESS ON CONTINUATION OF FAMILY PLANNING PROGRAM

(Mrs.) Judie Brown, president of the American Life League, challenged Congress on the continued funding of the Title X family planning program which she characterized as a "complete disaster." "Congress must ask some hard questions before reappropriating this program. We have provided documentation which would prove to the neutral observer that the program has been a failure to date and that it is doomed to exacerbate the very problem it was launched to resolve."

"When it was begun," said Brown, "the program was based on four assumptions: 1) That it would prevent abortion; 2) that it would reduce unwanted pregnancies; 3) that it would not stimulate sexual activity; and 4) that it would improve reproductive health."

"Unfortunately, however, even the research conducted by the major proponent of the program--Planned Parenthood Federation of America--shows that these assumptions have been proven invalid by the historical record of the program."

MORE......

JEREMIAH 1:5 BEFORE I FORMED YOU IN THE WOMB I KNEW YOU
ALL GIFTS ARE TOTALLY TAX DEDUCTIBLE

Brown pointed out that Dr. Robert Kistner of Harvard Medical School and Boston Hospital for Women admitted as far back as 1977 that "About ten years ago I declared that the pill would not lead to promiscuity. Well, I was wrong." This declaration has been validated by numerous studies since, that show increased sexual activity has been facilitated by the availability of birth control.

Mrs. Brown also challenged Members of Congress to examine the practices and policies of the agencies which receive Title X funds and operate the programs. "Planned Parenthood Federation of America has no compunction about breaking the law or evading the law. In the 1984 publication, The Human Right to Family Planning, authored by the president of PPFA, Faye Wattleton, and six others, it is written:

> "'Family Planning Associations and other non-governmental organizations should not use the absence of a law or the existence of an unfavorable law as an excuse for inaction; action outside the law and even in violation of it, is part of the process of stimulating change.'

"Further, PPFA has been allowed to manipulate and avoid the law by the Congress and the oversight agencies," said Brown. "In a PPFA sponsored symposium in 1971, Title X grantees were advised not to be concerned about being disqualified from receiving Title X funds if they performed abortions: 'There are obviously various accounting and technical devices which can be used so that the provision doesn't affect any abortion program adversely,' they were told."

In a final caution, Brown stated that a recent poll commissioned by Planned Parenthood came up with a number of results that were not anticipated and certainly not welcomed. "Their own poll shows that only 22% of those surveyed agreed with the PPFA-Title X 'solutions' to the teen pregnancy problem, i.e., providing contraceptive chemicals and devices and explaining those contraceptive means to teens. Fully 73% of the respondents suggested other solutions."

"In summary, Members of Congress have for too long allowed the fox to guard the chicken house. The public is not being well-served, because the teen pregancy problem has grown worse since the inception of the program. It is time for the program to be subjected to the close scrutiny of Congress and time to formulate a new plan to meet the challenge facing our nation," Mrs. Brown concluded.

# # #

MEMO TO EDITORS: A limited number of copies of the full testimony of Mrs. Judie Brown are available in the rack of the National Press Club. Additional copies available from A.L.L.

American Life League, Inc.

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Testimony of Mrs. Judith A. Brown
President, American Life League

March 14, 1986
Labor and Human Services Appropriations Subcommittee
House of Representatives

Mr. Chairman and Members of the subcommittee, since the inception of Title X in 1970, congressional support of subsidized birth control programs has been based on four assumptions about birth control: 1. That it prevents abortion; 2. eliminates adverse outcomes from unwanted pregnancies; 3. does not stimulate sexual activity; and 4.improves reproductive health.

While these assumptions have been repeated before House and Senate authorization and appropriations committees, none has been documented by proponents. Amazingly, in the absence of evidence, and in the face of a rising incidence of out-of-wedlock births, sexually transmitted diseases, and legal abortions, some of them facilitated under Title X by an accounting finesse, or the farce of Title X counseling and referral programs from grant recipients that are co-located with abortuaries, the Congress, since 1971, has provided more than $1.7 billion for the Title X birth control program alone.

Birth control proponents have long known from studies, some of them from Planned Parenthood (Pearl--1939; Stix/Notestein--1940), and from uncontested clinical experience (Kinsey/Planned Parenthood Conference--1955; Requena--1965 and 1969, reaffirmed by Potts 1981), that abortion is more frequent among birth control users than among non-contraceptors.

Moreover, Edward Pohlman, funded by Planned Parenthood, in a critical review of over 65 years of scientific research failed to establish any direct connection between unwanted conceptions and a tendency to have undesirable consequences. Topics examined included sickness in pregnancy, abortion--induced and spontaneous, emotional illness, divorce, marital friction, etc.

Studies from Sweden and England verify that women on the pill experienced more sexual partners whether they were unmarried university students or married women. Birth control proponents admit in their own literature, but not before congressional committees, a lower age of first intercourse, earlier exposure to unwanted pregnancy and a pill/promiscuity link.

Dr. Robert W. Kistner, of Harvard Medical School and Boston Hospital for Women, said in 1977 that "About 10 years ago I declared that the pill would not lead to promiscuity. Well I was wrong." Kistner noted indirect evidence for increased sexual activity was available from data which showed that in 1950 women under 25 with cancer in situ amounted to 30 percent of all women with cervical cancer, but almost 93 percent by 1967.

Public health professionals acknowledge that the change in unmarried sexual behavior over the past 15 to 20 years has been facilitated by increased birth control availability.

Yet, behind the announced public health and pregnancy prevention agenda, is another that occasionally surfaces. Deep within Planned Parenthood's 1985 Alan Guttmacher Report on Teen Fertility in Developed Nations is a discussion about the role which Scandinavian countries have played in providing a model for social change in the United States. The Planned Parenthood authors state that with so many out of wedlock births in Sweden [40 percent] the desirability of marital births and or childrearing had disappeared. They then note, evidently with some degree of approval, that this "process is beginning in the U.S. white population and is already well established among American blacks ... These as well as other changes perhaps imply that the U.S. will be following suit in eventually adopting more rational attitudes toward adolescent sexuality."

In what must certainly be unique in the annals of legislation, the U.S. Congress is funding the demise of the American Family under the Family Planning Program! This policy is the brainchild of the largest single recipient of Title X funds, the Planned Parenthood Federation of America--an organization which has long shown an interest in manipulating or even breaking the law to further its own ends, in spite of congressional statutes as can be seen below.

First, law breaking: In the 1984 The Human Right to Family Planning, authored by Faye Wattleton and six others we find "Family Planning Associations and other non-governmental organizations should not use the absence of law or the existence of an unfavorable law as an excuse for inaction; action outside the law, and even in violation of it, is part of the process of stimulating change" (Report of the Working Group on the Promotion of Family Planning as a Basic Human Right to the Members Assembly and the Central Council of the IPPF, published Nov. 1983, copyright, IPPF 1984, pages 20-21).

Second, manipulation of law: The end run around congressional intent in the Dingell anti-abortion provision of Title X was openly acknowledged at a 1971 Agency for International Developement-funded and Planned Parenthood-sponsored symposium, which was co-chaired by Dr. Lewis Hellman, then Deputy Assistant Secretary for Population Affairs and head of the Title X program. There, Planned Parenthood's own Dr. Christopher Tietze asked if Title X programs which performed abortion as a birth control procedure, or as a 'back up' for contraceptive failure would qualify for Title X funding. He was answered by Ruth Roemer of UCLA who claimed that Title X was vaguely worded, that she and others were working for a favorable interpretation, but in any case, she noted, "There are obviously various accounting and technical devices which can be used so that the provision doesn't affect any abortion program adversely." The record shows that Dr. Hellman did not challenge this statement.

Last year when the question of prohibiting abortion counseling came up, Planned Parenthood and other population control groups draped themselves in the First Amendment as if it were their exclusive property. The success of their effort, in my judgment, depended upon a general ignorance of what Planned Parenthood and its supporters meant by "abortion counseling." It is much more than keeping a list of physicians, so-called, and clinics where preborn babies are put to death.

(The following material is from Louise Tryer, M.D., FACOG, VP for Medical Affairs Manual of Medical Standards and Guidelines Executive Committee, PPFA--National Medical Committee, March 1980.)

Planned Parenthood's definition of "Pregnancy and Abortion Counseling" includes pregnancy testing, pelvic exam, birth control history (See S & G Sect. VII-C, Abortion, revised July 31, 1978, p. 21).

Qualifications and Training of Counselors: "The counselor must have a complete knowledge of the facts regarding abortion ... about the relative risks of early abortion as opposed to late abortion; availability of services; facility evaluation; costs of services. This wil require Affiliates to survey physicians and hospitals in their communities, to determine availability of services.

"Counselors must have knowledge regarding availability of insurance coverage or other reimbursements for abortion ... Any woman, regardless of age or marital status, shall be eligible for counseling. Any minor may be counseled and referred to a physician for appropriate care.

"Special attention must be given in scheduling women seeking pregnancy diagnosis and/or abortion to avoid delays which would place the woman beyond the first trimester at the time of the appointment for medical evaluation" (Part One--S & G Sect. VII-C, Abortion, December 1977).

Referral Fees and Contracts: "...a fee may be charged for counseling." "Under some government contracts, however, the Affiliate may bill the government funding agency on behalf of the patient and reimburse the abortion provider" (Part One--S & G Sect. VII-F, Abortion, March, 1980).

Planned Parenthood Redefines Abortion: "Endometrial Aspiration for the purpose of early termination of pregnancy is vacuum curretage of the uterus performed within 5 to 14 days after the expected date of menstruation in women in whom it is possible that unplanned, unwanted conception has occurred.

"In the woman who is not 'obviously pregnant,' however, a negative pregnancy test does not exclude this woman from being considered for endometrial aspiration" (Part One--S & G Sect. VII-B, Abortion, March 1980).

Additionally, Planned Parenthood proponents have noted, "We think all family planning agencies should be prepared to provide postcoital contraception... For clinics not prepared to perform abortions this policy would be extremely important, whether for licensing, liability insurance, accounting, or community relations." Or, it might be added, for securing continued federal funding from the U.S. Congress under Title X. (From a paper presented to the 1977 Association of Planned Parenthood Physicians, October 12-13, "Postcoital Contraception by Endometrial Aspiration," Eliot and McGreggor, copyright 1978, Excerpta Medica, pp. 21-16.)

You perhaps may have heard some of the results which Planned Parenthood wanted you to hear from their $80,000 poll conducted for the Planned Parenthood Federation of America by Harris and Associates. It may surprise you, but a number of their polling results do not support the continuation of the Title X program in its present form.

However, before I address those points, I call to your attention a number of the unstated assumptions contained in the PPFA poll.

1. The provision of birth control does not alter behavior to either initiate or continue sexual intercourse.

2. Only students already sexually indulgent will be given birth control as part of a school-linked clinic, i.e., not my child.

3. The provision of birth control will reduce out-of-wedlock teen pregnancies and abortions.

4. Chastity cannot be reinforced nor indulgence inhibited. Teen sexual behavior is basically uncontrollable.

5. Religion plays no role in sexual behavior and attitudes.

Additionally, there were a number of questions not asked such as:

1. Should parents have more control over their children in matters of sex education, birth control and behavior?

2. Should the church have more input into moral formation in these matters to reinforce family values?

3. What do you understand the content of sex-education courses to be, and would you favor them if it were shown that they altered your children's attitudes so they would be in favor of or see nothing wrong with premarital sex or homosexuality?

4. Is abortion a form of birth control?

As you have heard their side of the story, I will tell you some of the good news for the American family and the bad news for Planned Parenthood. Results that reflect a tilt toward pro-life attitudes in the short and long run:

First question: "What do you think is the most important thing that parents should do to help prevent their teenage children from either becoming pregnant or causing pregnancy?" Table four shows the result of the open-ended question: 5 percent responded "Give them/put them on pills or some form of contraception;" 17 percent responded "Explain birth control and contraceptive methods."

So, only 22 percent agree with Planned Parenthood's current program, while 5 percent responded "Don't know," and fully 73 percent suggested other solutions.

Second question: "I'd like to ask you some questions about the abortion issue. Do you favor or oppose a federal law prohibiting family planning clinics from giving birth control assistance to teenagers unless they have received permission from their parents?"

You see, Planned Parenthood cannot resist linking abortion and birth control under the heading of "family planning," yet they tell you gentlemen here that they are separate.

The results, shown in table ten show that in September of 1985, 48 percent of the respondents favored parental consent, 47 percent opposed and 5 percent responded "Not sure." This compares with results obtained in March of 1984 of 44 percent in favor, 53 percent opposed and 3 percent responding "Not sure."

The Planned Parenthood "sneak" policy of excluding parents from their children's birth control decisions--which is supported by congressional funding--has dropped in public support. The responses cited above are even more revealing in light of the question which immediately followed. It asked if respondents believed making contraceptives more difficult for teenagers to obtain would result in more pregnancies: 53 percent of the respondents believed it would result in more pregnancies, 18 percent felt it would result in fewer pregnancies and 19 percent felt it would have no effect.

This brings me to the most recent health masquerade of the de-population planners, namely, the High School Birth Control Outlets--also known as school based health clinics. The above-cited PP/Harris poll asked if public schools should be required "to establish links with family planning clinics, so that teenagers can learn about contraceptives and obtain them?" The results were: 67 percent were in favor, 29 percent opposed and 4 percent were not sure. (Table 20)

Recall, however the above public misconceptions and unverified assumptions regarding birth control preventing abortion and out-of-wedlock births. Recall, too, the missed pills and general inexperience of youthful birth control practitioners, none of which Planned Parenthood places in context for the participants in their Harris poll, and you can easily see the alleged "support" fade.

The publicity touting the alleged "success" of the school birth control (SBC) program claims a reduction in teen births. The "premiere" clinic in St. Paul, Minnesota, claims that the St. Paul student birthrate has been reduced from 59 births per 1,000 students in 1976-77 to 37 births per 1,000 students. However, even a Planned Parenthood writer has recently noted, "Whether the decline was due to a decrease in the number of pregnancies or to an increase in the reliance on abortion cannot be discerned" (Asta Kenny, "School Based Clinics: A National Conference Family Planning Perspectives, Vol. 18, No. 1, January/February 1986, pp. 44-46).

Ann Rickets, who administers the St. Paul Adolescent Health Services project, states that, "Teens who are given birth control, however, 'are followed intensively,' and 'this takes up a lot of our staff's time.'" Miss Hill Young, an attendee at the October, 1985 School Birth Control conference noted that, "We really keep a close hold on those kids." And "If they don't show up, we go get them. That's one of the advantages of being in a school." This is excellent training for the eventual introduction of a Red Chinese birth control-type program into this country with forced sterilization, abortion, etc. (Louise Kaegi, "School-Based Clinics: A Formidable New Twist in the Teen Sexuality Debate." Family Protection Report, Vol. VII, No. 11, November 1985, pp. 1-5).

A survey of representatives of SBC clinics at the Chicago SBC conference provided the followoing information respecting their source of funds: 45 percent Maternal and Child Health; 24 percent Medicaid's Early and Periodic Screening, Diagnosis and Treatment program; 29 percent Medicaid; 14 percent Adolescent Family Life program; 17 percent Title X Birth Control; 29 percent private; and 38 percent miscellaneous.

In addition to the above invasion of the taxpayers' pockets, the privacy rights of adolescents and their parents are violated by highly personal and sensitive questionnaires students are asked to fill out when they walk into the clinic.

A questionaire prepared by The Center for Population Options, the major single proponent of SBC, asks students if they have ever thought of suicide, ever made themselves vomit after a meal, ever used birth control, ever felt life was not worth living, what the source of parental income was, ever had a venereal disease, taken marijuana or hash, LSD, PCP, uppers or downers, speed, etc.

Additionally, I would like to submit for the record a copy of the actual survey with similar personal questions used at DuSable High School in Chicago.

I would be surprised if such questions did not violate sections 439(a) and (b) of the General Education Provisions Act (P.L. 90-247, as amended, 20 U.S.C. 1212h), commonly known as the Hatch Amendment.

And that these SBC clinics purport to be adolescent health centers as opposed to birth control outlets is rather farcical. A survey by the Center for Population Options published in April 1985, of 10 organizations running 23 SBC clinics, reported that individual counseling about sex was a major activity in all of the programs (100 percent), but that dental care was a major activity for only 20 percent; 80% described birth control as a major activity, while only 10 percent offered drug and substance-abuse counseling. Immunizations were a major activity at 40 percent of the clinics, but gynecological exams were a major activity at 80 percent of the clinics--with almost three-fourths conducting pelvic exams, which are, of course, needed for the pill.

And although parental consent is allegedly required for services at present, the clinics do not let parents select only some health services for their children. All "services," including birth control, must be accepted, or no services will be provided. So much for freedom of choice!

I note another discrepancy here. How can the Title X-funded clinics require parental consent, when the federal courts struck down an attempt by the Reagan administration to require, not parental consent, but the minimal parental notification? Are some parents being led astray by promoters of these SBC clinics? Is the current ploy to get these clinics established relying upon the blanket consent forms, and then later surprise the other parents as well when public funding replaces foundation support by telling them that Title X-funded programs cannot mandate parental consent?

And because example is the only teacher in such practical matters, I suggest that birth control and not self control will be looked at most favorably. This is suggested by a poll of 1,200 Planned Parenthood birth control clinic personnel. Researchers discovered that, "Overall, 90 percent of female personnel were using a contraceptive method." How can abstinence be counseled in such an atmosphere?

Furthermore, on the question of morality, Ms. Faye Wattleton, president of Planned Parenthood Federation of America, has stated that birth control associations, including Planned Parenthood, "should recognize that it is a mistake to enter into debates on questions of morality" (Human Right to Family Planning, etc.).

These are just a few of the problems of SBC clinics.

Returning to Title X program claims about increasing "reproductive health," the use of "modern" birth control has been associated with an increase in venereal diseases, and the prevalence of infertility. The costs are born both by men and women (gonorrhea, ectopic pregnancy, urethritis, pelvic inflammatory disease, pelvic surgery, hospitalization, etc.), and also by any future children they choose to have (chlamydia-induced pneumonia, conjunctivitis, Caesarean births, infant deaths, etc.).

Infertility: A summary of Cycle III of the National Survey of Family Growth conducted by the U.S. Public Health Service, which interviewed almost 8,000 women, reports the following:

	Percent Infertile		
Age/Race for Wives	1965	1976	1982
Total			
15-19	.6	2.1	2.1
20-24	3.6	6.7	10.6
25-29	7.2	10.8	8.7
White			
15-29	4.7	7.5	8.6
Black			
15-29	4.8	13.3	13.6

Thus, the percentage of infertile married couples as measured by surveys purporting to be statistically representative since 1965 has continued to increase in the very time period when contraceptive utilization was increasing, whether funded by the public or private sector.

Sexually Transmitted Diseases, Behavioral Changes, and Birth Control: Dr. Robert C. Barnes and Dr. King K. Holmes, writing in the Johns Hopkins School of Hygiene and Public Health Journal, note that "Between 1965 and 1968 the proportion of college-aged American women reporting premarital intercourse increased from 20 percent to 40 percent. In a comparison of rates of premarital intercourse in high school and college-aged American women, Chilman noted a 300 percent increase in premarital intercourse rates for white females between 1969 and 1974 ...

"In addition, by 1973, premarital intercourse in the United States was occurring in younger persons, with the proportion of 15- to 16-year-olds reporting prior intercourse being about 25 percent of whites of both sexes, 50 percent in black females, and 90 percent in black males.

"This increase in sexual activity occurred with a simultaneous (and perhaps contributory) change in the pattern of contraceptive practices in the United States. Oral contraceptives and contraceptive intrauterine devices became widely available, and this has been associated with the increased sexual experience of unmarried women.

Chlamydia trachomatis (CT) is now a common genital pathogen and probably the most prevalent cause of sexually transmitted disease in the United States at present. In different studies researchers have reported that the rate of pregnant women whose cervices are infected with CT ranges from 2 to 30 percent. Infants born to mothers with CT are at a 50 percent risk of contracting chlamydia during passage through the birth canal.

Its association with the "pill" derives from a claim that the pill is protective against pelvic inflammatory disease (PID). Howard Ory, M.D., chief of the Epidemiologic Studies Branch of the Family Planning Division, U.S. Centers for Disease Control wrote in 1982 for PP's AGI journal that 51,000 episodes of PID and 13,300 hospitalizations were prevented in the United States per year, based on an estimated 8.5 million current pill users. Ory claimed the evidence for this protective effect was firm.

Ory and others associated with Planned Parenthood's Alan Guttmacher Institute (AGI) repeated this claim in a 1983 AGI publication, Making Choices: Evaluating the Health Risks and Benefits of Birth Control Methods.

Ory's claim was seriously challenged in a well-researched review article in the April 19, 1985, Journal of the American Medical Association by Dr. A. Eugene Washington and three others.

Washington, citing Ory's 1983 AGI work, states that "Many clinicians have been influenced by these reports to prefer oral contraceptives for sexually active young women who have no contraindication to their use."

Washington notes that most published data on PID and its association with oral contraceptives are generally limited to hospital or hospital emergency room cases. However, since 75 percent of all PID episodes are managed on an outpatient basis, the 25 percent are not likely to be representative. Furthermore, they failed to differentiate between initial and recurrent episodes, and almost all failed to distinguish between gonococcal and nongonococcal PID. Chlamydia-associated PID is of the latter type and has initial symptoms that are milder than gonococcal PID.

Washington writes that "At best, the available studies only suggest that oral contraceptives may protect against clinically severe PID, where Neisseria gonorrhea plays an important role."

Washington cites 14 studies, 12 of which demonstrate a twofold to threefold increase in the prevalence of cervical C. trachomatis infection in oral contraceptive users. He acknowledges that the increase in C. trachomatis could be due to greater sexual activity or better clinical disease detection among pill users. A bias resulting from an increased Chlamydia detection ability could neither be concuded nor definitively ruled out from two studies examined.

Washington suggests that more evidence is needed to determine what factors account for the relationship between Chlamydia, the pill and PID, examining such factors as duration of pill use, type of pill, and microbial entities. However, he and his colleagues specifically recommend that "The choice of a reversible contraceptive must be expanded beyond considerations of reliability, convenience and acute medical complications to include concern about the long-term complications from PID, ectopic pregnancies and infertility."

Chlamydial infection has an estimated annual incidence of 3 million in the U.S., making it the most common sexually transmitted disease. Decisions about contraceptive use that tend toward the pill could have far-reaching public health consequences.

"Protection against clinically-apparent PID does not guarantee protection against tubal factor infertility. The present aggregate evidence could even disguise a promotion by oral contraceptives of chlamydial PID and its more common consequence of infertility. Microbiologic evidence suggests that the effects of oral contraceptives may be organism dependent and supports our concern that oral contraceptives may promote chlamydial PID by increasing infection rates."

In closing, I would like to discuss the claim Planned Parenthood voiced about the original Kemp Amendment. Namely, that such a prohibition would impinge on the ethical obligations of birth control providers who assert that they must provide a full range of birth control options.

We all know that Catholic-affiliated organizations that wish to remain faithful to Church teaching by providing only natural family planning cannot currently receive Title X funding because of the present HHS contraceptive and abortion referral provisions. Do such groups have a right to federal money? Not necessarily.

But why can't Congress tell Planned Parenthood, the American Public Health Association, the National Family Planning and Reproductive Health Association, etc., the same thing? Why can't Congress tell Planned Parenthood that they are not being compelled to state things they don't believe. They are or were being asked to perform a certain limited service for which they might receive federal money.

In fact, the American Civil Liberties Union has sued the Arlington Diocese Catholic Charities office, a Title XX recipient, because the ACLU claims the Catholic Charities office is indulging in certain prohibited speech. The speech that is prohibited is the suggestion that chastity is good for individuals. It is prohibited because it happens to embody the teaching of a particular religiously-affiliated organization that received federal money for a sex education course.

Therefore, both the ACLU and PP accept the notion that certain speech may not be subsidized by federal funding. They turn around and claim the opposite when the Congress declines to subsidize portions of their speech.

In summary, speech in support of chastity and virtue may not receive federal funding, while speech, drugs, devices and preparations that lead to a dead baby and one of more than 50 sexually-transmitted disease entities are entitled to constitutional protection and congressional funding!

If the Members here today want to continue to fund this anomalous situation that is, of course, their choice. I do suggest, however, that you consider at least the following questions:

1. Currently, HHS guidelines prohibit patient consent for permanent sterilization under age 21.In light of the possibility of pelvic inflammatory disease and the likelihood of permanent infertility from PID as a result of IUD or oral contraceptive use, shouldn't Congress consider a parental-consent requirement before dispensing such drugs and devices in federally-supported birth control clinics?
2. As the physician package insert on oral contraceptives requires that a complete medical history--including family predisposition to cancer--be taken, shouldn't Congress inquire whether or not Title X grantees who do not interview parents for such information are fulfilling their congressionally imposed responsibility under the Food and Drug laws?
3. At present, Title X grantees are not required to screen for gonorrhea, except perhaps where an IUD is requested. Shouldn't Congress require gonorrhea screening of all individuals with more than one sexual associate in the previous six months?
4. Because Chlamydia appears to be an even greater problem than gonorrhea, shouldn't Congress require screening of women on the pill at least once every six months?
5. Shouldn't Congress require a minimum age of 17 as a condition of eligibility for recipients of any birth control drug, device or chemical under Title X and other federally-subsidized birth control?
6. Shouldn't Congress require screening of additional sexually transmitted diseases, including AIDS, in federal birth control programs.

I further ask that the record be kept open for 30 days of additional material the American Life League and others might wish to submit to the Subcommittee pertinent to Title X.

Thank you, Mr. Chairman and Members.

DuSable Clinic
DuSable High School
Chicago Public Schools

CONSENT TO ENROLL MINOR IN

DuSABLE CLINIC

NAME OF MINOR: ____

ADDRESS: ____

BIRTHDATE: ____________________ PHONE #: ____________________

I do hereby request, authorize, and consent to the enrollment of my son/daughter or minor for whom I am legal guardian in the DuSable Clinic.

I understand that all services are free, and that I will not be charged for any services my son/daughter receives in the Clinic.

I understand that my signing this consent allows the physicians and professional Clinic staff of the DuSable Clinic to provide the following comprehensive health services:

1. Emergency treatment
2. Routine school and sports physical exams
3. Immunizations
4. Appropriate laboratory tests
5. Examination, diagnosis, and treatment of complaints of pain or ill feeling identified by my child
6. On-going care of existing medical conditions
7. Treatment of sexually transmitted diseases
8. Pregnancy testing, prenatal and post partum examinations
9. Family planning, including pregnancy prevention
10. Professional counseling in regards to nutrition, personal hygiene, sexuality, substance abuse, family and relationship issues and other health related areas

For further information about the Clinic or any of its services, feel free to call ____ __________________ or drop into the Clinic, Room __________ DuSable High School.

PARENTAL CONSENT FOR HEALTH SERVICES

I do hereby give my informed consent for my son/daughter ______________ to receive the services offered by the DuSable Health Clinic and to complete confidential questionnaires. Furthermore, I release the Chicago Board of Education and its members, officers, employees, agents and representatives from any and all claims, suits, actions, liabilities, legal costs, and attorneys' fees arising out of the operation of the DuSable Health Clinic.

______________________________ ____________________

Signature of Parent/Guardian Date

ATTACHMENT C

PSYCHOSOCIAL EVALUATION

given by a psychologist to all clients
DuSable High School (Chicago)
Univ. [illegible]
[illegible]

Name ____________________ Date ____________________

Age ____________________ Div. ____________________

Sex ____________________

(1) If you could change your life, what would you do? ____________________

(2) What are your thoughts and feelings about birth control? ____________________

(3) Have you started having sex? Yes ___ No ___ If yes, are you using contraceptives (protection)? What type? condom/rubber ___ jellies/foam ___ IUD ___ Pill ___ Diaphragm ___ If no, are you interested in using contraceptives? Yes ___ No ___

(4) Do you have a child? Yes ___ No ___

(5) Have you ever been pregnant? Yes ___ No ___

(6) Have you ever gotten anyone pregnant? Yes ___ No ___

(7) With whom do you live? ____________________

(8) Do you get along with your parents? Yes ___ No ___ Sometimes ___

(9) Do you have any sisters or brothers? Yes ___ No ___
If so, do you get along with them? Yes ___ No ___

(10) What is your relationship like with your boyfriend/girlfriend? ____________________

(11) What do you worry about most of the time? ____________________

(12) Do you sleep well at night? Yes ___ No ___

spelling!

(13) Have you ever smoked marijuana?	Occassionally ___	Sometimes ___	Never ___
(b) Used drug by needle?	Occassionally ___	Sometimes ___	Never ___
(c) Used Cocaine?	Occassionally ___	Sometimes ___	Never ___
(d) Used Heroine?	Occassionally ___	Sometimes ___	Never ___
(e) Taken LSD?	Occassionally ___	Sometimes ___	Never ___
(f) Taken pills not prescribed by doctor?	Occassionally ___	Sometimes ___	Never ___

FRIDAY, MARCH 14, 1986.

FAMILY PLANNING COUNCIL OF WESTERN MASSACHUSETTS AND NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION, INC.

WITNESS

LESLIE TARR LAURIE, EXECUTIVE DIRECTOR

Mr. NATCHER. Our next witness is Mrs. Laurie. Come around, Mrs. Laurie.

Ms. LAURIE. Thank you, Mr. Natcher.

Mr. CONTE. Mr. Chairman, I would like to welcome Leslie Laurie, she is both a constituent of mine and a national spokesperson for the family planning program. We take her word very seriously around here, as you know Mr. Chairman.

I don't want to overlook one of my newest constituents, the beautiful little girl, Rebecca. Leslie and her husband, Bruce, are bringing up a new generation of Conte supporters, I hope. We are very pleased to have you both here today.

Mr. NATCHER. We are glad to have you, and when you go back to your District and talk to your people, you tell them you heard one fellow say that Silvio Conte is one of the best members of the House.

I have been here a year or two. I have served with about 2,000 members, and he is one of the best.

Now, we will be pleased to hear from you.

Mr. CONTE. Thank you, Mr. Chairman.

Ms. LAURIE. I would like to speak briefly in support of Title X, but I would appreciate if my formal statement could be put into testimony at a later date.

Firstly, I would like to introduce myself. I am Leslie Tarr Laurie, and I represent the National Family Planning and Reproductive Health Association, the largest family planning organization representing consumers and providers across the country.

I am also the Executive Director of Family Planning Council of Western Massachusetts. Since 1981, I have testified every single year on behalf of Title X, and last year, I was not able to do that, because I did decide that it was important in the First Congressional District to have more supporters for Silvio Conte, so we are doing what we can for planned family planning, but also to make sure that important Congressmen stay in office.

I also very much wanted to thank this committee, even though it is a belated thank you, for the very good judgment that it showed in resoundingly rejecting the Kemp-Hatch Amendment, which would have caused havoc, not only to the Family Planning Council of Western Massachusetts, but for all programs across the country.

It would have afforded us the ability to not be able to provide important information to individuals who need information, and what the Kemp-Hatch Amendment would have done would have ensured that especially poor women would not have been able to get the same information that rich women did about all of the options related to family planning and abortion.

We thank you for the important judgment that that showed. I think Faye Wattleton accurately and quite well described the important successes that the family planning has had, and why it is essential for family planning to continue.

I would like to introduce a comment by another Massachusetts Congressman, Tip O'Neill. He indicates that all politics are local. For us, all of the programs which you decide to fund are really local.

Even though you can hear about significant statistics, and the global concerns that we have for family planning, it really is on a local level that the family planning program has had success, and why the kinds of fiscal constraints that we now confront make it even more important for family planning to get important support.

I would like to say that from 1981 to the present, the Family Planning Council of Western Massachusetts has served over 14,000 individuals on an annual basis, and we feel very good about the women and men who have been able to get important health care through our program, but it is a very sad commentary when there are over 43,000 women and men in western Massachusetts who still need subsidized family planning services.

What we are doing at this point is barely treading water. In the First Congressional District, there are three of the highest levels of teenage pregnancy in the Commonwealth of Massachusetts.

Athol, Holyoke and Springfield are three areas of our State which need more rather than less family planning services, and what we are confronting now as we face the beginning of our fiscal year in April is a 4.3-percent cut automatically, and rather than being able to open our doors to individuals who need service, what we are now finding is we have over a six-week waiting list for individual who even want responsibly to use contraceptive services.

And I would like to share one thing which happened to me yesterday before I came down to Washington. Holyoke is a city within western Massachusetts, and one in which there has been great difficulty in many areas, and teenage pregnancy is one of them.

And yesterday, I had an opportunity to meet with the Superintendent of Schools of the Holyoke school system, and for the first time, what this individual wanted was for the Family Planning Council of Western Massachusetts to provide family life education to every single eighth grader in Holyoke, and he also asked we do teacher training and begin in September to provide educational services for sixth graders.

And I needed to tell him that while we were delighted that the Family Planning Council was an organization that the Holyoke school system was interested in seeing provide educational services, I was not certain about what I was going to be able to do, because of the resources to provide that needed educational work.

So what I want to summarize in saying is that I think the Title X program, as evidenced by the program in western Massachusetts, has done very important educational work within our communities and right now, there is a tourniqet around the family planning program, and we are being squeezed as far as we can be squeezed, and the effects that are now occurring within our communities are those which I don't think this committee would like to see.

So, I would hope even in the time of fiscal constraints that what we could see is a continuation of the important investment in Title X, and I would strongly concur that $147 million is not enough, but recognizing what is happening now, it is all we can really ask.

I have always felt family planning services are important, and I think that after having a planned child and one that needed to have quite a bit of medical care, and will need to have quite a bit of medical care in the future, it is essential that individuals have the right to choose when and if they want to have children.

This committee has always supported that important right for American women and men, and I would hope, even given what is happening now in Washington, that you will continue with that endeavor, so thank you so much for allowing me to speak this morning, and I would be happy to answer questions if there are any that you would like to pose.

Mr. CONTE. Thank you, Leslie, that was a very good statement.

Mr. NATCHER. You have made an excellent statement. We appreciate your appearance before the committee.

Ms. LAURIE. As you can see, Rebecca Laurie also has a lot to say, and I hope in a few years, it will be able to be translated, so it is understandable.

Mr. NATCHER. Thank you very much.

[The statement of Ms. Laurie follows:]

NFPRHA National Family Planning
and Reproductive Health Association, Inc.

TESTIMONY
OF
LESLIE TARR LAURIE
ON BEHALF OF THE
NATIONAL FAMILY PLANNING
AND
REPRODUCTIVE HEALTH ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON LABOR, HEALTH AND
HUMAN SERVICES, AND EDUCATION
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
ON THE TITLE X (PHS ACT)
FAMILY PLANNING PROGRAM
MARCH 14, 1986

122 C Street, N.W., Suite 380, Washington, D.C. 20001-2109 (202) 628-3535

RECOMMENDATIONS OF THE NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION FOR FISCAL YEAR 1987 APPROPRIATIONS FOR THE TITLE X (PHS ACT) FAMILY PLANNING PROGRAM

1. Reject administration efforts to place federal support for family planning services into a primary care block grant and reauthorize Title X for three years.

2. Resist all efforts to compromise the quality, confidentiality, or scope of Title X services by opposing mandatory parental consent requirements and restrictions on family planning counseling and referral.

3. Appropriate $150,930,000 for programs under Title X: $147,000,000 for service program grants and contracts; $3,400,000 for training program grants and contracts; and $530,000 for the development and testing of informational and educational materials and programs. These figures are equal to the fiscal year 1987 authorization levels approved on May 15, 1985 by the House Energy and Commerce Committee in H.R. 2369, the reauthorization legislation for Title X.

4. Appropriate $126,700,000 for the Center for Population Research within the National Institute of Child Health and Human Development.

5. Appropriate $20,000,000 for the specific development and evaluation of new or improved contraceptives.

Mr. Chairman and Members of the Subcommittee:

I am Leslie Tarr Laurie, Executive Director of the Family Planning Council of Western Massachusetts and former President of the National Family Planning and Reproductive Health Association, Inc.(NFPRHA). I want to thank you and this subcommittee for the opportunity to address the issue of continued funding for programs under Title X of the Public Health Service Act, "Population Research and Voluntary Family Planning Programs."

The National Family Planning and Reproductive Health Association (NFPRHA) is a national nonprofit membership association headquartered in Washington, D.C., established to improve and expand the delivery of voluntary family planning and reproductive health care services throughout the United States. As the only national organization representing the entire family planning community, from consumers to state, county and local health departments; from hospital-based clinics to affiliates of the Planned Parenthood Federation of America; from umbrella funding councils to independent private nonprofit clinics and individual health care professionals, NFPRHA is committed to establishing and maintaining reproductive health care as a high priority preventive health care service in this country.

Title X is the primary source of federal funding for subsidized voluntary family planning services in this country. Since its inception in 1970, the national family planning network under Title X has enjoyed broad bipartisan support in Congress. I urge you and your Congressional colleagues to sustain that long-standing commitment to quality reproductive health care for all by appropriating $150.93 million for Title X programs in Fiscal Year 1987.

In this year of budgetary austerity, the federal investment in family planning is more valuable than ever before.

Title X is a medical program that serves the poor and the medically indigent.

Title X clinics are the entry point for millions of low-income women and adolescents into the nation's health care system.

An estimated 800,000 unintended pregnancies, including 425,000 among teenagers, are prevented each year as a direct result of the national family planning program.

Every federal dollar invested in Title X results in a two-dollar savings in public health care and social services costs in the next year alone. And for teenagers, the cost benefit ratio represents a three-dollar saving for every dollar spent.

Typical Title X programs offer clinical health services (physical examinations, contraceptive information and services, pap tests, venereal disease screening and treatment, cancer screening, hemoglobin tests, urinalysis, pregnancy testing and diagnosis, and basic gynecological care); counseling services (for adolescents, medical problems, parent/teen, nutrition, infertility, maternal and child health, and problem pregnancies); services for men (counseling, education, condoms); special teen clinics; adolescent health education programs; and community education programs.

The need for continued support for Title X is clear and considerable. Even with Title X, fifty-six percent of the 9.5 million low-income women and 69 percent of the five million sexually-active teenagers in need of subsidized family planning services cannot obtain medically supervised reproductive health care.

Federal, state, and local financial support for family planning has never reached a level commensurate with need. Since the early 1970's, the number of medically indigent family planning clients has grown more than 60 percent, yet federal funding for family planning has not increased in real dollars since 1973.

In the last five years, Title X's appropriation has gone from $162 in FY 1981 to $142.5 million in FY 1986 before the Gramm-Rudman-Hollings recisions. Inflationary increases alone should have brought the current level of Title X funding to $210 million by this year.

The Gramm-Rudman-Hollings deficit reduction law is expected to cut non-exempt social programs to one-third of their current budgets by 1991. For Title X, the cuts will result in the elimination of services to over 1 million medically indigent women and adolescents. The irony of this is, of course, that a program which has proven as cost-efficient and effective as Title X will be cut, resulting in far greater social and financial costs down the line.

Despite Title X's record of accomplishment, the Reagan administration has consistently sought to repeal the Title X program for ideological and political reasons, and failing that, to significantly reduce the program's funding and undertake administrative harassment designed to destroy the integrity and efficacy of the national family planning program. The clinics have stayed open, but the belt-tightening shows. Operating hours have been reduced, staff have been cut, and indigent patients have been asked to contribute more to the cost of services.

While struggling with draconian budget cuts, Title X grantees have also suffered an unprecedented number of audits in the past five years. Instigated by the Department of Health and Human Services Office of Inspector General and the General Accounting Office, the audits failed to find a single violation of law or regulation.

Family planning providers have had to fight legislative and judicial contests over confidential services for teenagers. Attempts to institute nationwide mandatory parental consent for all minors receiving Title X family planning services, both administrative (the infamous "Squeal Rule") and legislative (the Helms/Dannemeyer amendment), have failed. No evidence suggests that such restrictions will forestall teenage sexual behavior, but there exists ample evidence that such restrictions will aggravate the crisis in teenage childbearing we already face in this country.

Title X providers have also had to fend off the Kemp/Hatch amendment and similar attempts to restrict pregnancy counseling and referral. Medical ethics and legal notions of informed consent require that a physician provide information on all medically indicated legal options. Kemp/Hatch would not prevent poor women from seeking out abortions, but only undermine the quality and efficacy of Title X services. Women who depend on federally subsidized reproductive health care services have as great a right to complete information about all safe and legal medical options as those who can afford care from private practitioners.

Title X funds have never subsidized abortion procedures. Yet, under the guise of opposing abortions, some individuals and groups have sought to undermine the single most effective federal program for reducing the need for abortion -- Title X.

Despite the attempts of the Reagan administration, the successes of the Title X family planning program cannot be ignored, and they speak forcefully for the reauthorization of Title X for three years and for NFPRHA's request that this subcommittee and Congress approve an appropriation for Title X for fiscal year 1987 of $150.93 million. NFPRHA is encouraged by the movement of S. 881 in the Senate and H.R. 2369 in the House, bills to reauthorize Title X through fiscal year 1989, and looks forward to the passage of this legislation in the Congress.

Title X is a medical program serving poor Americans, but it also authorizes contraceptive research and development, and research in the reproductive and behavioral sciences. The development of improved methods of contraception could help reduce the number of unintended pregnancies in this country, which accounted for 55 percent of all pregnancies last year. Less than ten percent of the current budget of the Center For Population Research of the National Institute of Child Health and Human Development (NICHD) goes for contraceptive development. For that reason, NFPRHA requests that Congress appropriate $126.7 million for

NICHD population reseach and grant a special additional appropriation of $20 million each year for the next five years to focus on improving contraceptive technology.

SUMMARY

For fiscal 1987, NFPRHA requests that Congress fund Title X at its full authorization level of $150.93 million, and support contraceptive development with a special supplementary fund of $20 million. Adequate funding of family planning and contraceptive research programs will send a strong message that Congress and this committee hold reproductive health care as a high priority, even in these times of fiscal constraint.

Thank you very much for your consideration of our requests. I would be happy to answer any questions you may have.

FRIDAY, MARCH 14, 1986.

NATIONAL COMMUNITY ACTION FOUNDATION

WITNESSES

DAVID BRADLEY

RONALD LEE LOGSDON, EXECUTIVE DIRECTOR, AUDUBON AREA COMMUNITY SERVICES, INC.

Mr. NATCHER. Our next witness is Dr. David Bradley.

Mr. BRADLEY. I am David Bradley, and I am here to discuss the Community Services Block Grant, and I would like to point out a couple of things to the committee that you can consider and keep an eye on during your important deliberations this year.

In terms of the Administration's request, again, they are requesting zeroing out the Community Services Block Grant; their major emphasis on requesting that elimination is that the program duplicates the Social Services Block Grant.

Consequently, because of the duplication, it is not needed.

In their testimony before this committee and in the testimony before the authorizing committees, as well as the budget committees, they do not attack the community action agencies, but simply the Community Services Block Grant.

The General Accounting Office will be releasing a study this week, this upcoming week, March 20, that totally refuted the Administration's arguments in terms of duplications of the program.

The GAO, in testimony before the House authorizing subcommittee and in a report to be issued in a few days, will say that there is no duplication between Social Services Block Grants and Community Services Block Grants, it complements—the money is used for administration, supportive services, and community action agencies need the program to stay in business.

So, the GAO report is fairly important to deliberations on our program this year.

The second thing I wanted to point out to you is that I feel relatively confident that we are going to be in both the House and Senate budget resolutions, that deliberations that are taking place on the Senate side now appear to be including, and will include the Community Services Block Grant, so we should not have a major fight on appropriations on the Senate side over that program.

The third thing I wanted to point out to the committee is that we are going to be reauthorized this year. The bill will be introduced Monday or Tuesday in the House, bipartisan, cosponsors, and the ranking Republican on the full Education and Labor Committee, as well as the ranking Republican on the subcommittee, will be sponsoring that bill, a four-year period.,

The mark-up, March 20 on subcommittee and full mark-up following that. The Senate side will also reauthorize the Community Services Block Grant, and I think Senator Hatch will be cooperative this year in getting that program through.

So the issue surrounding the Community Services Block Grant are looking fairly favorable. I hope you keep an eye on those. The finding about the program, the only thing we need to tell you is that the committee has been very, very important in our survival for the last few years, and the first few years, the Reagan Administration, without this committee, we wouldn't be here.

This program is prepared to take its fair share of cuts, its fair share in any freeze, and we trust that the deliberations that you will undertake in the next couple of months will look at our needs, and look at where the program was in 1981 and where the funding is now, and how the demand for services has increased, and simply do the best you can.

We trust this committee, you are important to our survival, and we need your continued support very much.

Mr. Chairman, with me is, by accident today, is Ron Logsdon from Kentucky. We appreciate all of your support.

Mr. NATCHER. Thank you, Mr. Bradley.

You brought to the committee a friend of ours from Kentucky, and we appreciate it. Thank you very much, and we are glad to have you back before the committee, and I am glad to hear that this authorization is about ready to go.

Thank you very much.

FRIDAY, MARCH 14, 1986.

AMERICAN LIBRARY ASSOCIATION

WITNESS

EILEEN D. COOKE, ASSOCIATE EXECUTIVE DIRECTOR

Mr. NATCHER. Ms. Cooke. Come around, Ms. Cooke.

You are the Director of the American Library Association, and you have appeared before our committee on a number of occasions, and each time it has been a pleasure having you before the committee.

Ms. COOKE. Thank you, Mr. Chairman.

I appreciate the opportunity to appear on behalf of our membership of over 42,000 librarians, trustees and educators, friends of libraries, dedicated to the improvement of library service.

We are very pleased to be here at an earlier date than usual. Your recent change of schedule for ALA's appearance has somewhat constrained the amount of detail we are able to put together for you on Federal library programs.

However, you know these programs well. I am sure it does not surprise you that the Administration has, for the fifth year in a row, recommended elimination of the Federal programs which support libraries. The subcommittee has been supportive in the past.

I feel sure that, despite the pressures of the Gramm-Rudman-Hollings balanced budget legislation, you will continue to support a small but crucial Federal role to stimulate and encourage the most effective library services to the American people.

However, the Administration has gone further this time, and recommended recision or cancellation of all fiscal year 1986 library grant funds that have not already been substantially allocated.

My appearance before you today instead of a month and a half from now gives me the opportunity to discuss the mischief and hardship this proposal causes during the 45-day period of Congressional review.

ALA recommends that this subcommittee reject the proposed recision of all funding for the Library Services and Construction Act Title II public library construction, LSCA VI library literacy programs, the Higher Education Act Title II-B library training, research and demonstration, and HEA II-C research library grants.

A total of $34.5 million was appropriated for these programs, before the March 1 Gramm-Rudman-Hollings sequestration, in the fiscal year 1986 L-HHS-ED appropriations bill, H.R. 3424, Public Law 99-178. Thus, you have already rejected the Administration's original request to eliminate LSCA and HEA II in fiscal year 1986.

In the case of LSCA II, the recision proposal is just plain illegal. If you will recall, in fiscal year 1982, LSCA funds were proposed for recision, and funding was held up even before a recision requested was submitted to Congress.

A lawsuit was filed by 10 States, but funds were not released until after the recision period expired. However, the General Accounting Office ruled that Impoundment Control Act provisions for recision proposal do not supercede statutory mandatory spending provisions such as those for LSCA I, II and III.

Despite the GAO opinion, the Administration is holding up all LSCA II funds during the recision period, including those of two States, Massachusetts and Michigan, which had already received fiscal year 1986 allocations.

A third State, Oklahoma, had an application approved by the Education Department, but was told all funds would be withheld, at a point before Gramm-Rudman-Hollings was signed into law, and well before any recision request was submitted.

A February 21 memo from the Education Department to State library administrative agencies, plus follow-up memo to the States involved, will require 16 States to "deobligate" LSCA I funds, and 17 States to "deobligate" LSCA III funds to the extent necessary to comply with the Gramm-Rudman-Hollings sequester order which took effect March 1.

This was apparently seen as the lesser of two evils. The Department's alternatives were to pull back funds from States which had already received allocations, or impose a double cut on States which had not yet received allocations.

Undoubtedly, if almost half of the States had not already received funds, LSCA II and III would also be part of the recision request.

Nationwide, about 210 public library construction projects are affected by the proposed recision. Each project submitted to State library agencies for approval must include a commitment of matching funds. Local communities can only hold matching funds for so long before other demands are made on them.

Recission of first-time funding for LSCA VI library literacy programs would eliminate about 192 projects and prolong the costly problem of illiteracy.

As the Business Council for Effective Literacy pointed out in its January 1986 Newsletter for the Business Community:

> One of the key reasons that libraries are so well positioned to play a larger role in literacy programming is that they already are centers for numerous other communi-

ty activities. Moreover, they are open evenings and weekends, and offer a friendly environment free of any negative associations with schools or past school failure.

For an adult to go to a library is a prestigious act, whereas going to an elementary or secondary school for night classes often feels demeaning. Furthermore, for new literates to have acquired the habit of going to a library is desirable in itself, because it may lead them to continue reading independently.

HEA II-B grants to library education programs for fellowships could have been announced in December, allowing institutions to recruit the best candidates. II-B has concentrated on minority candidates for graduate degrees.

The need is great, but attracting such candidates into a relatively low-paying field without the assurance of financial support is difficult; even with such support, it takes time. The number of minority students enrolled in library schools has dropped more than 40 percent since 1979, mainly due to decreased funds for II-B.

The Education Department has already received 97 HEA II-C research library grant applications for about 43 awards. Preparation of these proposals cost libraries about $1 million. The Department has already convened and paid expenses for two panels to review these proposals.

It does not make sense to abandon this process in midstream, especially in light of the following statistics:

There are 6 to 7 million unique bibliographic records for books of academic significance that do not yet appear in nationally available online catalogs, meaning scholars have limited access to a large body of knowledge.

About one-fourth to one-half of all paper in library book collections is in such poor condition that further use may result in loss of text.

Without treatment, all but about 10 percent of the remainder of book collections are expected to reach the same brittle state. 10-year data from 84 research libraries shows that they increased spending on books by 93 percent and on serials by 155 percent, but increased their holdings by only 31 percent, due to increased costs of materials.

These current funded library programs are small but vital and important. Funds have been appropriated and in some cases allocated; plans have been made based on clear Congressional intend to fund, and for some projects matching or other funds have been promised.

The 45-day recision delay alone means over half the current fiscal year will go by before recipients receive their money. Approval of the recisions would cause great disruption in library services; in some cases, salaries are at stake.

Many of the points I have been making about the programs proposed for recision also apply to the Administration's zero funding proposal for fiscal year 1987. Federal funding now accounts for only 4 percent of public library support, but LSCA enables libraries to reach that part of the population without library services or with very inadequate services, or for whom provision of library service requires extra effort or special materials and equipment.

LSCA I allows libraries to be innovative in using technology. For instance, Florida and New Jersey are among the States using radio reading services to reach the visually impaired. Libraries in Arizona and Colorado are pioneering in using computers to serve the handicapped.

The first use of a Chinese-Japanese-Korean language computer terminal in a public library took place in California with LSCA I funds. In Kentucky, LSCA I funds provide services to a number of State institutions, including correctional facilities and State hospitals and schools; in some institutions, computer literacy programs are offered along with books and audio-visual materials.

A major trend in LSCA III projects continues to be increased use of computers and communication technologies, especially including smaller libraries' participation in the creation of machine-readable bibliographic data bases.

These promote and enhance the capabilities of libraries to share resources across local and State boundaries, a very appropriate Federal role. Wisconsin tested telefacsimile machines in several academic, public and State-level libraries. The technology was found to be fast, effective and cost-efficient for academic and large public libraries for interlibrary loan use.

For the most part, library networks depend on the Postal Service for delivery of materials to other libraries. The fourth class library rate increased 37 percent since January 1 due to two increases caused by insufficient appropriations plus the Gramm-Rudman-Hollings cut.

If the revenue forgone appropriation is eliminated as the Administration proposes, there would be a 74-percent increase in the library rate in a nine-month period. The cost of the telecommunications lines used by thousands of libraries to connect to nationwide bibliographic data bases has also risen several times in the past year.

The likely end of revenue sharing after this year will also affect libraries. In West Virginia, 22 percent of local library support actually comes from Federal revenue sharing. All libraries will feel the pinch as local governments look for places to cut to replace revenue sharing funds now being used for police and fire protection and other local services.

The list of stresses and strains on libraries caused by Federal budget cuts and Administration policies is a long one this year. The $18.3 million cut to the fiscal year 1986 budget of the Library of Congress affects all libraries across the country.

The majority of the cataloging and classification of books held in U.S. libraries is done by the Library of Congress, which makes its bibliographic data available through catalog cards, book catalogs, and computer tapes.

As the Nation's premier research library, the Library of Congress has subject, language and technological expertise no other single library can match. A small library can often rely on Library of Congress cataloging data for close to 100 percent of its needs. However, Library of Congress will catalog 25,000 fewer books this year.

The Library of Congress National Library Service for the Blind and Physically Handicapped is being reduced 12 percent. Its braille and recorded books and magazines are distributed to the visually impaired with the cooperation of 160 regional and sub-regional libraries for the blind, many of them supported in large part by LSCA I.

Now, 80,000 fewer copies of braille and recorded magazines will be available. Elimination of postal revenue forgone funding would threaten free mail for the blind, another Federal program which supports this service.

In addition, libraries are finding it more and more difficult and expensive to meet their users' needs for information by and about the Federal Government, due to agency budget cuts and Administration policies.

As agencies' budgets are cut, information and data collection, analysis, and dissemination activities are often reduced or eliminated. Policies promulgated in recent years years by the Office of Management and Budget call into question the appropriateness of such activities, and accelerate the trend toward commercialization and privatization of government information.

As a result, much useful information may no longer be disseminated through the Federal depository library system, almost 1,400 libraries located in every Congressional District, may be available only from a private-sector firm at a high price, or may simply not be collected or computed at all.

For instance, the Federal Communications Commission will publish in the Federal Register only summaries, not the full texts, or proposed regulations, rulemaking decisions and policy statements.

The Agriculture Department can no longer report the total poundage of food consumed per capita in the U.S., due to discontinued crop reports. The Food Institute says the gaps prevent meaningful comparisons in fruit and vegetable areas, identifications of changes in the national diet, et cetera.

I mention these trends to put Federal library programs in context, and to emphasize that continuing these small programs is all the more essential in light of other pressures on libraries from the Federal level.

I would like to call to your attention the fact that the HEA II-A college library resources program is being amended to target grants to the neediest institutions as suggested by Congressional committees.

The II-A need criteria included in the HEA reauthorization legislation passed by the House, H.R. 3700, and approved by the Senate Education Subcommittee, S. 1965, scheduled for full committee mark-up next week, were developed by the academic library community.

ALA recommends that you consider funding II-A at $5 million, which would provide grants of between $2,000 and $10,000 to about the 1,000 neediest academic libraries.

Included in the Education Consolidation and Improvement Act, Chapter 2, State block grant to the schools is the former ESEA IV-B School Library Resources and Instructional Equipment Program.

The best that can be said for the impact of Chapter 2 on school libraries is that the effect is uneven. Some school libraries receive more funds than they had under categorical grants, while others receive none.

A recent study of elementary school libraries in New York City found that most reference books date from the 1960s, few new materials were purchased, and one librarian even had to send damaged books home for parents to mend.

Several Department of Education-sponsored report in the last few years have emphasized the importance to literacy and the learning process of reading: The National Commission on Excellence in Education's "A Nation at Risk," the ED Libraries and the Learning Society Advisory Board's "Alliance for Excellence," the Commission on Reading's "Becoming a Nation of Readers," and most recently, "What Works: Research About Teaching and Learning."

"What Works" notes: "Children improve their reading ability by reading a lot. Reading achievement is directly related to the amount of reading children do in school and outside." What better places for reading or sources of reading material than well stocked and staffed school and public libraries?

I am pleased to see that the Administration has recommended continuation of funding for the National Commission on Libraries and Information Science. This unique cost-effective agency works to identify, examine and seek solutions for problems in areas including the information needs of the aged and rural citizens, adult literacy, information's effect on productivity, and access to government information for decisionmakers.

Each week the pending legislation, H. J. Res. 244 and S. J. Res. 112, to authorize a second White House Conference on Library and Information Services attracts additional cosponsors.

NCLIS would be the administrative agency for planning and implementing such a conference. In December, NCLIS approved a report of its WHC Preliminary Design Group.

This excellent report proposed library and information services for productivity, for literacy, and for democracy as the three overarching themes of the 1989 WHC. ALA recommends funding for NCLIS at a level sufficient to allow it to carry forward its programs effectively.

The Department of Education has recommended for fiscal year 1987 a considerably increased amount for its reorganized Center for Statistics. We support this recommendation if it means that basic data about all types of libraries will be collected, analyzed and made available in a regular and timely fashion. Such data collection and dissemination should be one of ED's key functions.

I am also pleased to see that after several years without a specific authorization, the Medical Library Assistance Act has been extended as part of the Health Research Extension Act, Public Law 99-158, and is authorized at $13 million in fiscal year 1987.

ALA recommends funding sufficient to continue current services for the Medical Library Assistance Act and the National Library of Medicine.

I appreciate your past support of this great national library, and remind you that 1986 is the library's sesquicentennial year. As Congress noted in a commemorative resolution, "The health of American citizens has been improved as a result of the rapid access to biomedical information enjoyed by health practitioners utilizing the services of the National Library of Medicine."

In summary, ALA strongly urges that this subcommittee reject the Administration's proposed recisions of fiscal year 1986 library program funding, and that you recommend funding level for fiscal year 1987 that would enable continuation of programs at current service levels, figured before the Gramm-Rudman-Hollings sequestration.

Thank you for the opportunity to present the views of the American Library Association.

Mr. NATCHER. Thank you very much, Mrs. Cooke. You have made an excellent statement. We appreciate your appearance before the committee.

[The attachments to Ms. Cooke's statement follows:]

SUMMARY OF AMERICAN LIBRARY ASSOCIATION APPROPRIATIONS RECOMMENDATIONS
FY 1987 Labor-HHS-Education Appropriations

Library Programs	FY 1986 Appropriation	FY 1986 After 4.3% Sequester[1]	FY 1986 Rescission Proposal[2]	FY 1987 Authorization	FY 1987 Reagan Request	FY 1987 ALA Recommendation[3]
Library Services & Construction Act TOTAL	$120,500,000	$115,318,000	-$26,318,000	$170,000,000	-0-	$126,525,000
Title I, Public Library Services	75,000,000	71,774,000	-	85,000,000	-0-	78,750,000
II, Public Library Construction	22,500,000	21,533,000	-21,533,000	50,000,000	-0-	23,625,000
III, Interlibrary Cooperation	18,000,000	17,226,000	-	30,000,000	-0-	18,900,000
IV, Indian Libs.	(funded at 2% setaside of appropriations for LSCA I, II, & III)					
VI, Lib. Literacy	5,000,000	4,785,000	-4,785,000	5,000,000	-0-	5,250,000
Higher Education Act TOTAL	$ 7,000,000	$ 6,699,000	-$6,699,000	$ 30,000,000[4]	-0-	$ 12,350,000
Title II-A, College Lib. Resources	-0-	-0-	-	12,500,000[4]	-0-	5,000,000[5]
II-B, Lib. Training and Research	1,000,000	957,000	-957,000	5,000,000[4]	-0-	1,050,000
II-C, Research Libraries	6,000,000	5,742,000	-5,742,000	12,500,000[4]	-0-	6,300,000
Education Consolidation & Improvement Act Chapter 2 El/Sec Educ. State Block Grant[6]	528,909,000	506,166,000	-	such sums	528,909,000	555,354,000
National Commission on Libraries & Info. Science	690,000	660,000	-	750,000	690,000	725,000
Center for Statistics, ED (incl. library surveys)	8,747,000	8,371,000	-	14,000,000	12,000,000	12,000,000
Natl. Lib. of Medicine (incl. Medical Lib. Asst. Act)	57,808,000	55,322,000	-	such sums	56,408,000	60,698,000

[1] Balanced Budget-Emergency Deficit Control Act (Gramm-Rudman-Hollings Amendment) required 4.3% cut March 1, 1986.
[2] ALA recommends that Congress reject the Administration's rescission proposals for library programs.
[3] ALA recommends funding at amounts required to maintain the current level of services (before G-R-H sequester).
[4] As in House-passed HR 3700; Senate Subcommittee's S. 1965 has $5,000,000, $1,050,000 and $6,300,000 for II-A, B & C.
[5] Would fund about 1,000 neediest institutions under need criteria included in both HR 3700 and S. 1965.
[6] Forward funded consolidation of 28 programs incl. former ESEA IV-B School Library Resources and Instruct. Equipment.

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

May 6, 1982

B-205053

LSCA [illegible]

To the President of the Senate and the
Speaker of the House of Representatives

On February 5, 1982, the President's eighth special message for fiscal year 1982 was transmitted to the Congress pursuant to the Impoundment Control Act of 1974. The special message proposed 22 rescissions of budget authority totalling $10,655 million, 14 new deferrals totalling $2,334 million, and revisions to seven previously reported deferrals which increase the amounts deferred by $768 million. On February 19, 1982, the President submitted his ninth special message for fiscal year 1982, reporting a $2 million reduction in the amount proposed for rescission in rescission proposal R82-23 (Mine Safety and Health Administration). In his eleventh special message for fiscal year 1982, dated April 23, 1982, the President reduced by $3.4 billion the amount proposed for rescission in rescission proposal R82-21 (subsidized housing programs).

The 45-day period during which the funds proposed for rescission could be withheld pending congressional consideration of a rescission bill ended on Friday, April 23, 1982, without Congress having passed any such bill. The withheld funds were released by OMB on Monday, April 26, 1982.

In our report to Congress dated March 10, 1982, we explained in detail our interpretation of section 1001(4) of the Impoundment Control Act, the so-called "fourth disclaimer," which provides that the Act does not supersede any other provision of law requiring the obligation or expenditure of budget authority. Briefly stated, our analysis requires examination of the statutory scheme involved for evidence of a congressional mandate to spend the funds appropriated for the particular program. In the following report, we identify the rescission proposals submitted in the eighth and ninth special messages which involve mandatory spending programs under our analysis of section 1001(4). In our view, the Impoundment Control Act does not authorize impoundments of funds for these programs.

[illegible]

FUNDS APPROPRIATED TO THE PRESIDENT

R82-4 International Development Assistance
Functional Development Assistance Program
Food and Nutrition
Education & Human Resources
11X1023
11X1025

R82-5 International Development Assistance
Sahel Development Program
11X1012

DEPARTMENT OF AGRICULTURE

R82-6 Extension Service
1220502

DEPARTMENT OF COMMERCE

~~R82-7~~ ~~National~~ Oceanic and Atmospheric Administration
Coastal Zone Management
13X1451

R82-8 National Oceanic and Atmospheric Administration
Coastal Energy Impact Fund
13X4315

DEPARTMENT OF EDUCATION

✓ R82-9 Office of Elementary and Secondary Education
Compensatory Education for the Disadvantaged
91209
912/30900

The following programs in which funds were proposed for rescission involve a mandatory spending statute under our analysis of the fourth disclaimer: education for the disadvantaged, ~~Title~~ I, Elementary and Secondary Education Act, 20 U.S.C. §§2802, 2832, 2841, 2843, 2851 (general provisions); §2711(a) (basic grants); §2721(a), (b) (special incentive grants); §2722(b) (grants to areas with concentration of low-income families); §2761 (migrant children); §2711 (handicapped children); §2781 (neglected and delinquent children).

Program officials informed us that fiscal year 1982 grants for programs for compensatory education for disadvantaged students for the 1982-1983 school year are scheduled to be made beginning in July 1982. They also told us that grants to colleges for education services to migrant workers were to be made beginning in April 1982.

R82-10 Office of Elementary and Secondary Education
Special Programs and Populations
9121000
912/31000

With regard to the State Student Incentive Grant program, agency officials told us that the current full funding level would support 295,000 awards, not 307,000 as stated in the special message.

Program officials also said that it is difficult to estimate the exact effect of the proposed rescission because the average award amount is subject to change and the schools may use up to 15 percent of their allocation for job location programs and administrative expenses. However, the officials said that the rescission proposed for the college work-study program probably would reduce the number of grants by more than 70,000. The officials told us that the estimated reduction of 70,000 awards apparently was calculated on the basis of an average award of $600, without considering the fact that Federal funds account for only 80 percent of each award. If the calculation is revised to consider the non-Federal matching share, the proposed rescission of $44 million would eliminate approximately 90,000 awards.

R82-16 Office of Postsecondary Education
Higher and Continuing Education
9120201
91X0201

The following programs in which funds were proposed for rescission involve a mandatory spending statute under our analysis of the fourth disclaimer: public service fellowships, 20 U.S.C. §§1134d-1134g; aid to land-grant colleges, 7 U.S.C. §§321-329.

R82-17 Office of Educational Research and Improvement
Libraries
9120104

The following program in which funds were proposed for rescission involves a mandatory spending statute under our analysis of the fourth disclaimer: Library Services and Construction Act (grants), 20 U.S.C. §§351c-351e.

According to program officials, $12.7 million under Title I, LSCA (public library services) and $3.2 million under Title III, LSCA (inter-library cooperation) has been expended to date from fiscal year 1982 funds. No fiscal year 1982 funds have been expended for the other two programs proposed for rescission (college library resources and research libraries).

FRIDAY, MARCH 14, 1986.

THE GERONTOLOGICAL SOCIETY OF AMERICA

WITNESS

JOHN M. CORNMAN, EXECUTIVE DIRECTOR

Mr. **NATCHER**. Our next witness is Mr. John Cornman. We will be pleased to hear from you at this time.

Mr. **CORNMAN**. Thank you, Mr. Chairman.

My name is Jack Cornman, and I am the Executive Director of the Gerontological Society of America which represents 6,000 researchers and educators in aging. My testimony today will be directed at the budgets for the National Institute on Aging for the Center on Aging at the National Institute of Mental Health and on the Title IV programs of the Administration on Aging.

I will be submitting a more detailed statement following the hearing and today I would just like to put in the record some thoughts on the common stake people of all ages have in gerontological research.

Despite some comments, recent comments in the media, which might suggest otherwise, the aging of our society is a success story and it is also a challenge. More people are living longer.

The quality of life for increasing numbers of elderly is better than for previous generations. Much of this progress can be credited to all the successful investments and advancements made by past and present generations in addressing the problems across the life course, including investments in research.

While these trends are proof of success, they also present a new and multidimensional challenge. This challenge includes: one, preventing, postponing, limiting and managing the functional disabilities associated with the chronic illnesses that often accompany old age, especially advanced old age; two, finding ways to meet the income and health care needs of the elderly through both individual effort and private and public sector programs; three, slowing down the expected rate of increase in costs—especially health care costs—associated with such care; and, four, developing ways to increase the likelihood that the years being added to life expectancy are both satisfying and productive. Finally, this challenge also involves—and indeed cannot avoid—doing all this while improving the quality of life for all members of society, regardless of age.

Investing in research on aging is one of the principal ways of responding to this challenge and of charting the course of an aging society. Public and private decision makers need information about: one, demographic, economic, health, and other trends among the elderly; two, the kinds and levels of needs for services these trends will create; and, three, the kinds and numbers of personnel required to meet these needs.

Of equal if not greater importance is the need for new knowledge which may alter some of the less attractive aspects—for example, the projected increase in demand and in expenditures for caring for the functionally disabled elderly—and help maximize the opportunities emerging from an aging society.

We can better understand the potential returns on such an investment by reviewing some strides research has made thus far in responding to both the challenge of and the opportunities presented by an aging society.

New knowledge may lead to ways of reducing debilitating impacts of chronic illness for some elderly and their families as well as some associated costs to individuals, families, and society. Research on the problem of incontinence, which afflicts an estimated 2.6 to 4.7 million elderly persons could significantly reduce the number of people in nursing homes and allow some incontinent individuals to remain at home in the care of relatives for a greater length of time.

In fact, if research and education efforts have only a five percent impact on nursing home admissions during the next twenty years, conservative estimates say nursing home expenditures would be reduced by about $1.125 million per day.

One area where some progress is being made, but much more is needed, concerns Alzheimer's disease and related dementias. Although "the great majority of people maintain good mental functioning into their later years, the proportions of those who acquire a significant degree of dementia rise rapidly among the very old", with an estimated one in five persons aged 80 and over having a serious, irreversible dementia. Moreover, an estimated 30 percent to 50 percent of patients in nursing homes have Alzheimer's disease.

Between now and the year 2000, an approximately 50 percent increase is projected in the number of nursing home beds needed. Half or more of this increase and much more of the increased need for community-based, long-term care services are related to the expected needs of persons experiencing severe dementia. Clearly as a society, we have a major stake in basic and applied research leading to prevention, reduction of incidence, and/or treatment of this and other devastating diseases.

The challenge of an aging society also involves developing ways to increase the likelihood that the years being added to life expectancy are satisfying and productive, both for individuals and society. Investing in research, one, can help improve the health of future cohorts of the elderly; two, can help ensure that the elderly and very old continue to contribute to the development of society through work and community involvement.

For example, research has shown that disease prevention, health promotion, and proper nutrition can greatly increase the likelihood of reaching old age. Of course, this kind of research has helped improve the health of younger people along the way. Exercising and no smoking can have beneficial effects at any age.

Using the talents of the elderly serves the interests of the society as well as of the elderly. With more people projected to live longer, it seems likely that a significant portion of the future elderly may be both willing and able to work longer. Research being conducted today can provide the information needed—including developing ways to retain older workers beyond the normal retirement age—to assist employers and employees in adjusting to an aging work force.

While current cohorts of the elderly often benefit directly from such research, indirect benefits also accrue to persons of all ages. For example, indirect benefits of research on aging may include decreased health care costs to taxpayers and reduced caregiving costs—financial, emotional, and physical—to families who provide support to older relatives.

Further, the actual benefits of most research on aging very often accrue to those who are not old. For instance, research on osteoporosis, a condition particularly noticeable among postmenopausal women, has resulted in a prescription for preventive maintenance involving diet, exercise to develop and maintain bone mass, and other life-style factors for women of all ages.

Indeed, research focused on a particular concern of an aging society may benefit only future cohorts of the elderly. But although today's elderly and perhaps even today's middle-aged may never benefit personally from some of this research, the knowledge that flows from their investments in research will be transferred as a legacy to future generations in society.

In a very fundamental way, then, research on aging is an intergenerational transfer of great benefit to persons of all ages as well as to those yet to be born. It is an investment in our common future.

Funding for the National Institute on Aging, under the Administration's proposal, would be reduced from $156.5 million in fiscal year 1986 to $145.8 million in fiscal year 1987, a 7 percent reduction. In general, this would mean that no new initiatives would be funded, and that all other programs would be continued but at reduced funding levels.

For example, NIA could support only 145 competing research grants in fiscal year 1987, as compared to 201 in fiscal year 1986. In addition, funding would be reduced for the ten Alzheimer Disease and Related Disorders centers, which conduct basic research on the disease as well as look at how to implement social supports and family care.

NIA's training program is slated for a 7.2 percent reduction in fiscal year 1987, while the National Institute of Mental Health's clinical training program would be totally eliminated. Reducing the number of funded training positions severely threatens the Nation's ability to address the well-documented shortage of health and allied health professionals.

The Title IV program under the Older Americans Act would be severely reduced under the Administration's proposal, which calls for a 50 percent funding reduction. This comes at a time when the Acting Commissioner of the Administration on Aging has made some positive attempts to reshape the Title IV program.

For example, the Commissioner has developed an approach for continually assessing training needs within the field of aging. This type of baseline information is critical to setting realistic training goals and in determining how effectively these goals are being met.

Recognizing the tight fiscal constraints facing Congress in fiscal year 1987, the Gerontological Society strongly urges you to continue these programs at a minimum at current services levels. As I have attempted to emphasize in my remarks here today, an investment in these research and training programs may ultimately benefit us all through such indirect benefits such as decreased health care costs to taxpayers and reduced caregiving costs, as well as a healthier old age through improved health practices in earlier ages.

[The statement of Mr. Cornman follows:]

STATEMENT

OF

JOHN M. CORNMAN

Executive Director, The Gerontological Society of America

PRESENTED TO

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

COMMITTEE ON APPROPRIATIONS

UNITED STATES HOUSE OF REPRESENTATIVES

ADDRESSING THE

FY 1987 APPROPRIATIONS

Research, Education, and Training in Aging

March 14, 1986

OFFSET
CAMERA COPY

Chairman Natcher and distinguished members of the Subcommittee, I am John Cornman, Executive Director of The Gerontological Society of America. The Gerontological Society is the national, scientific organization of researchers, educators, and other professionals in the field of aging. Founded in 1945, the Society now serves 6200 members around the world and includes many outstanding scientists in the field of biology, clinical medicine, the behavioral sciences, and social research, policy analysis and planning. A major concern of the Society is the development and application of knowledge in all aspects of aging.

My testimony today is on behalf of the Gerontological Society and is directed specifically to the FY 1987 budgets for the National Institute on Aging, for the Center on Aging at the National Institute of Mental Health, and the Title IV program of the Administration on Aging.

Despite some recent comments in the media to the contrary, the aging of our society is both a success story and a challenge!

More people are living longer. The quality of life for increasing numbers of elderly people is better than that for previous generations. Much of this progress can be credited to all the successful investments and advancements made by past and present generations in addressing the problems across the life course, uncluding investments in research.

While these trends are proof of success, they also present a new and multidimensional challenge. This challenge includes 1) preventing, postponing, limiting, and managing the functional disabilities associated with the chronic illnesses that often accompany old age, especially advanced old age; 2) finding ways to meet the income and health care needs of the elderly through both individual effort and private and public sector programs; 3) slowing down the expected rate of increase in costs--especially health care costs--associated with a growing older population; and 4) developing ways to increase the likelihood that the years being added to life expectancy are both satisfying and productive. Finally, this challenge also involves--and indeed cannot avoid--doing all this while improving the quality of life for all members of society, regardless of age.

Investing in research on aging is one of the principal ways of responding to this challenge and of charting the course of an aging society. Because an aging society is a new phenomenon, there is little experience to guide future actions. Public and private decision makers need information about 1) demographic, economic, health, and other trends among the elderly; 2) the kinds and levels of needs for services these trends will create; and 3) the kinds and numbers of personnel required to meet these needs. Of greater importance is the need for new knowledge which may alter some of the less attractive aspects (e.g., the projected increase in demand and in expenditures for caring for the functionally disabled elderly) and help maximize the opportunities emerging from an aging society. We can better understand the potential returns on such an investment by reviewing some strides research has made thus far in responding to both the challenge of and the opportunities presented by an aging society.

Research in Response to the Challenge of an Aging Society

One clear implication of population trends associated with an aging society is that there will be a greater need for long-term care services for functionally disabled older persons residing both in institutions and at home.

New knowledge may lead to ways of reducing debilitating impacts of chronic illness for some elderly and their families as well as some associated costs to individuals, families, and society. Research on the problem of incontinence, which afflicts an estimated 2.6 to 4.7 million elderly persons (OTA Report), could significantly reduce the number of people in nursing homes and allow some incontinent individuals (who might otherwise have been institutionalized) to remain at home in the care of relatives for a greater length of time (OTA Report). In fact, if research and education efforts have only a 5 percent impact on nursing home admissions during the next twenty years, conservative estimates say nursing home expenditures would be reduced by about $1.125 million per day. Similarly, investments in pharmaceutical and basic research are likely to "provide new therapies for many of the conditions that impair the functional ability of many of today's elderly...[and] lead to significant reductions in the severity of chronic illness among the elderly and in the cost of health care for this growing segment of the U.S. population" (OTA Report).

One area where some progress is being made, but much more is needed, concerns Alzheimer's disease and related dementias. Although "the great majority of people maintain good mental functioning into their later years, the proportions of those who acquire a significant degree of dementia rise rapidly among the very old," with an estimated one in five persons aged 80 and over having a serious, irreversible dementia (T. Franklin Williams testimony, 1983). Moreover, an estimated 30 percent to 50 percent of patients in nursing homes have Alzheimer's disease (OTA Report).

To date, gerontological research on Alzheimer's disease has provided new evidence that the nucleus basalis, the part of the brain that directs brain cells to communicate with one another, is the first area to degenerate ("Special Report on Aging", NIA). In addition, research has 1) shown that carefully structured environments and daily schedules can assist patients and their families in managing this disease; 2) has led to increasing recognition on the clinical level of the absolute necessity of ruling out "potentially treatable causes of dementia before concluding that a person has Alzheimer's disease"; 3) has begun testing the effectiveness of pharmaceutical approaches to treating Alzheimer's (T. Franklin Williams testimony); and 4) has begun to identify the organic basis for the disease.

Between now and the year 2000, an approximately 50 percent increase is projected in the number of nursing home beds needed. Half or more of this increase (T. Franklin Williams testimony) and much more of the increased need for community-based long-term care services are related to the expected needs of persons experiencing severe dementia. Plainly, as a society, we have a major stake in basic and applied research leading to prevention, reduction of incidence, and/or treatment of this and other devastating diseases.

Research in Response to the Opportunities Presented by an Aging Society

The challenge of an aging society also involves developing ways to increase the likelihood that the years being added to life expectancy are satisfying and productive, both for individuals and society. Investing in research 1) can help improve the health of future cohorts of the elderly; 2) can help ensure that the elderly and very old continue to contribute to the development of society through work and community involvement; and 3) can help identify ways the talents of a growing and increasingly better educated older population can serve society.

For example, research has shown that disease prevention, health promotion, and proper nutrition can greatly increase the likelihood of reaching old age. Of course, this kind of research has helped improve the health of everyone along the way. Exercising and not smoking can have beneficial effects at any age. Similarly, proper nutrition can reduce the risk of diabetes, coronary heart disease, and stroke (OTA Report). Additional research can provide new ways of promoting health in old age, thereby improving the quality of life and possibly reducing anticipated health care costs to society. Clearly, the payoffs that emerge from such research are widely distributed across generations.

Using the talents of the elderly serves the interests of the society as well as of the elderly. With more people projected to live longer, it seems likely that a significant portion of the future elderly may be both willing and able to work longer. Research being conducted today can provide the information needed--including developing ways to retain older workers beyond the normal retirement age--to assist employers and employees in adjusting to an aging work force.

In short, the research on aging done in response to the challenge of an aging society is an intergenerational transfer that will potentially play a large role in shaping the future, a transfer in which each generation, including the not yet born, have a common stake.

All Generations Benefit From Research on Aging

While current cohorts of the elderly often benefit directly from such research, indirect benefits also accrue to persons of all ages. For example, indirect benefits of research on aging may include decreased health care costs to taxpayers and reduced caregiving costs--financial, emotional, and physical--to families who provide support to older relatives.

Further, the actual benefits of most research on aging very often accrue to those who are not old. For instance, research on osteoporosis, a condition particularly noticeable among postmenopausal women, has resulted in a prescription for preventive maintainance involving diet (e.g., maintaining proper calcium intake), exercise to develop and maintain bone mass, and other life-style factors for women of all ages (OTA Report).

Indeed, research focused on a particular concern of an aging society may benefit only *future* cohorts of the elderly. But although today's elderly and perhaps even today's middle-aged *may never benefit personally* from some of this research, the knowledge that flows from their investments in research will be transferred as a legacy to future generations in society. In a very fundamental way, then, research on aging is an intergenerational transfer of great benefit to persons of all ages as well as to those yet to be born. It is an investment in our common future.

FY 1987 Administration Proposal and Its Impact

Funding for the National Institute on Aging, under the Administration's proposal, would be reduced from $156.5 million in FY 1986 to $145.8 million in FY 1987, a 7% reduction. In general, this would mean that no new initiatives, such as studying gender differences in aging, would be funded, and that all other programs would be continued but at reduced funding levels. For example, NIA could support only 145 competing research grants in FY 1987, as compared to 201 in FY 1986. In addition, funding would be reduced for the ten Alzheimer's Disease and Related Disorders centers, which conduct basic research on the disease as well as look at how to implement social supports and family care.

NIA's training program is slated for a 7.2% reduction in FY 1987, while the National Institute of Mental Health's clinical training program would be totally eliminated. Reducing the number of funded training positions severely threatens our ability to address the well-documented shortage of health and allied health professionals.

The Title IV program under the Older Americans Act would be severely reduced under the Administration proposal, which calls for a 50 percent funding reduction. This comes at a time when the Acting Commissioner of the Administration on Aging has made some positive attempts to reshape the Title IV program. For example, the Commissioner has developed an approach for continually assessing training needs within the field of aging. This type of baseline information is critical to setting realistic training goals and in determining how effectively these goals are being met.

GSA Funding Recommendations for FY 1987

In my comments, I have outlined the demographic trends and the new and multifaceted challenges they will present, particularly to you as members of Congress. Key decision makers such as yourselves will need up-to-date information to effectively chart and respond to an aging society.

In the past, Congress has demonstrated an understanding of the importance of gerontological/geriatric research and training through its support of the National Institute on Aging and the National Institute of Mental Health. These programs, as highlighted earlier, are beginning to make major advancements, and their potential for making significant contributions in the future is great. This momentum must not be slowed.

Recognizing the tight fiscal constraints facing Congress in FY 1987, the Gerontological Society strongly urges you to continue these programs **at a minimum** at current services levels. As I have attempted to emphasize in my remarks here today, an investment in these research and training programs may ultimately benefit us all through such indirect benefits such as decreased health care costs to taxpayers and reduced caregiving costs, as well as a healthier old age through improved health practices in earlier ages.

Mr. NATCHER. We want to thank you for your statement. We appreciate your appearance before the committee.

FRIDAY, MARCH 14, 1986.

NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS

WITNESS

DONALD J. McCONNELL, PAST PRESIDENT

Mr. NATCHER. Our next witness is Mr. Donald J. McConnell. Come around, Mr. McConnell. You have been before our committee many times.

Mr. McCONNELL. Yes, I have.

Mr. NATCHER. We are delighted to have you back and we will pleased to hear from you.

Mr. McCONNELL. Thank you very much.

Representative Conte, I am only a little below you in Connecticut.

Mr. CONTE. That's a nice part of the world. I have to take the chairman up there one of these days.

Mr. McCONNELL. We thank you very much, Representative Natcher, and Representative Conte, and your members for allowing us to make a statement here. I am Donald McConnell, Executive Director of the State Alcohol and Drug Abuse Administration in the State of Connecticut and also the immediate past president of the National Association of State Alcohol and Drug Abuse Directors.

That is an association of all single State agency directors throughout the States and the territories and I would just like to say a few things about our problem and then what we would like your Appropriations Committee to take a serious look at.

First of all, when we look at the third party payment system in the States, whether it be private insurers or public insurers, the medicaid/medicare system, we are one of the stigmatized type of health care services that are typically left out of this.

Hospital services are paid for upfront. The only thing medicare will pay for is detoxification of alcoholics or drug addicts and some methadone maintenance, but that in our minds is not really cost effective.

If we look at the HCFA study and the NIAAA study, combined, they prove that the feasibility and cost effectiveness of extending medicare and medicaid reimbursement for non-hospital alcohol treatment services was successful in documenting a cost effectiveness and extensive savings in this reimbursement policy.

Recently in the State of Connecticut Blue Cross ran a demonstration program on paying for out-patient alcoholics, which was much more cost effective. The system itself forces people into the highest cost of treatment when much of this treatment is neither wanted by the suffering alcoholic nor is it effective.

They just sober up and walk after a $3000 a day detoxification where we could keep them in a non-hospital setting or out-patient setting for much less. Where insurance is mandated in Connecticut, for instance, for 45 days of in-patient treatment most of the clients go for in-patient treatment.

In New York, where mandated is out-patient treatment most of the people initially go to out-patient treatment and most out-patient treatment is effective for these people.

So I think it is something that should be looked at and perhaps in the line of cost effectiveness medicaid/medicare should go beyond just detoxification payments and look at the alcohol and drug abuse system.

As we look at the President's budget request for alcohol, drug and metal health block grant for fiscal year 1987, it is suggested that $490 million, that represents for the alcohol and drug field about 245 million.

This represents a 43 percent reduction from fiscal year 1980 level of Federal funding for alcohol and drug abuse programs when adjusted for inflation. In fiscal year 1980, the level for alcohol and drug abuse was $332 million.

The current fiscal year, 1986, the appropriation is for the alcohol, drug and mental health block grant as you know, is $468.9 million, and that will be post-Gramm-Rudman and the alcohol and drug part of that is 235 million.

So we are going down while the demand for our services is going up. NASADAD recommends members of the committee appropriate the full amount that has been authorized for the ADM block grant for fiscal year 1987, which is 576 million.

The alcohol and drug portion of the appropriation would be 292 million, an amount which remains substantially below the fiscal year 1980 appropriation of 332 million. But it would provide some welcome relief for the ever increasing demands being placed on our system of services, increasing demands made by public awareness due to the drunk driving scenario, due to patients' groups around the country, 8,000 of them, due to the cocaine addicts and the rise of cocaine among high school students at 300 percent.

IV drug users, afraid of contacting AIDS, are coming into treatment now at the methadone level and the demand is going up. We have waiting lists in our methadone clinics all over the country. Connecticut right now I have 190 people on the waiting list three months to get detoxed from heroin and six months to get on a maintenance dosage.

Mr. CONTE. That's comparatively good. In my city of Holyoke, it is one year.

Mr. MCCONNELL. That is right, and in New York and New Jersey it is longer, Representative Conte.

So due to the allocation formula change authorized by Public Law 98-509, only one-half of the States have received an increase in their ADM block grant award since fiscal year 1984.

The States which did receive an increase in fiscal year 1985 and 1986 were the ones required to absorb the $21 million reduction and the block grant mandated by Gramm-Rudman-Hollings balanced budget legislation.

That is our situation. The Institute of Medicine Report on Progress and Prospects for the Alcohol, Drug and Mental Health Administration Research Programs cited exciting research being undertaken by NIAAA and NIDA in emphasizing the levels and range of opportunities for productive alcohol and drug research have never been greater.

The report included a recommendation for an annual commitment to the alcohol and drug research of $100 million per institute. The President's fiscal year 1987 request for NIAAA research and research training is $58 million.

NASADAD recommends 72 million at least for research and $1.8 million for research training to NIAAA. So we are coming in below the Institute of Medicine which very seldom has ever in my years of service put a number on anything they recommend under the National Academy of Science, but they are coming in for a recommendation of 100 million for research.

When you look at the President's recommendation for NIDA, National Institute of Drug Abuse Research and Research Training, it is 74.4 million. NASADAD recommends 90.5 million for NIDA research and 1.9 million for research training.

When you add the age research that has to be done for IV drug addicts and alcoholism being an immuno-depressant in itself, we need this money in these institutes for research to help us out in our States and in our nation. NASADAD further recommends fiscal year 1987 appropriation for clinical training of $1 million per institute, $1 million for NIDA, $1 million for NIAAA and that the money be Directly appropriated to those institutes rather than via the National Institute of Mental Health Clinical Training Program.

When the money for clinical training was taken out of NIDA and NIAAA and money was put in NIMH, we don't get much training in the—drug and alcohol training from our mental health confreres. We are in different fields and people have to recognize that a little bit more these days, I think.

Finally, NASADAD is extremely concerned about the disproportionate reductions in the prevention and knowledge transfer activities of the Institutes under the Gramm-Rudman-Hollings bill.

What happened is that when they got the 4.3 percent sequestration, they took 4.3 percent out of the direct operating budget so with paperclips and paper and personnel, the prevention effort which is the only partnership we have left with the Federal Government through NIDA and NIAA got a 20 percent cut so it was not a 4.3 percent cut.

So as it played out, what we are asking for is a separate line item be established in the NIDA and NIAAA budget to break out knowledge and transfer activities so they don't take a hit.

That is what they took with the 4.3 percent. I think next year if the same thing lays out with the larger 25 percent cut we are hearing about with Gramm-Rudman, that prevention activities and knowledge transfer from the Federal to the State governments is going to be wiped out.

I would finally like to add this as a corollary. Yesterday I went to a hearing of Representative Hughes' committee where Senator Conte did make a statement and we are supporting H.R. 526 with all our hearts. It is a very exciting bill.

I did ask Senator Hughes or Representative Hughes if he could go for a 50/50 split because that was the questions he was asking between enforcement and treatment, rehabilitation and education.

So we are supporting the State and local Narcotics Control Assistance Act with all our hearts and we also would like to mention in this regard that the Presidential Commission on Organized Crime has asked for more money to cut down on the demand.

It is one thing to work on the supply. We are trying to cut down on the demand and take care of the casualties and this is needed. So I thank you for your attention and your courtesy in listening and if there are any questions that either of you have, I will be glad to try to answer them.

Mr. NATCHER. Thank you, Mr. McConnell. We appreciate your appearance before the committee and you have made an excellent statement.

Mr. McCONNELL. Thank you.

[The statement of Mr. McConnell follows:]

STATEMENT OF
NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS
BEFORE THE
HOUSE COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON APPROPRIATIONS FOR LABOR, HHS, EDUCATION AND RELATED AGENCIES
ON
FEDERAL APPROPRIATIONS FOR ALCOHOLISM AND DRUG ABUSE PROGRAMS IN FISCAL YEAR 1987

MARCH 14, 1986

Dear Chairman and Members of the Subcommittee:

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) is pleased to have this opportunity to present a statement for the record on the President's Fiscal Year (FY) 1987 budget request for the programs administered by the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA).

NASADAD is a not-for-profit organization whose membership is comprised exclusively of the officially designated State agencies for alcohol and drug abuse treatment and prevention. These State agencies have the responsibility to plan and administer a statewide system of alcoholism and/or drug abuse prevention and treatment services.

INTRODUCTION

The Chairman and Members of the Subcommittee are already familiar with the range, complexity and seriousness of the problems which result from alcohol and drug abuse. These problems impact on every sector of our society, transcending socioeconomic levels, race, age and sex. Following is a quote from the October, 1984 Institute of Medicine (IOM) Report, entitled Research on Mental Illness and Addictive Disorders: Programs and Prospects, which documents the significant, negative consequences of these disorders:

> "Mental disorders and addictive states, especially when severe or chronic, cause personal, economic, and social upheaval both for afflicted individuals and for those close to them. In the United States alone, conservative estimates suggest that mental disorders and addictions directly afflict 30 to 45 million people and cost $20 billion annually in direct health-care expenditures. They contribute especially to morbidity, using such measures as utilization of long-term care and Social Security Disability, and the indirect costs to society, including lost productivity, social services, and crime control. Overall, yearly direct and indirect expenses total an estimated $185 billion."

The IOM report also concludes that "economic consequences of the disorders under the ADAMHA purview are comparable to those for heart disease and cancer." Yet, Federal support for these disorders is clearly inadequate. For example, in the case of alcohol research, for every research dollar spent on alcoholism and alcohol abuse in 1981, $35 was spent on cancer; $15 was spent on heart and vascular disease; and $4 was spent on respiratory disease.

As with alcohol research, Federal support for alcohol and drug treatment and prevention services is grossly inadequate. The FY 1986 or current funding level for the alcohol and drug portion of the Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant is $238 million, a 45 percent reduction from the FY 1980 level of $332 million, when the total is adjusted for inflation. The President's Commission on Organized Crime recognized the declining Federal support for treatment and prevention services and in its Report to the President has recommended that "greater Federal resources be devoted to programs to reduce demand". It further called for "a responsible contribution to the States for their own programs in this area".

Even with diminishing Federal support, most States have been able to maintain their services system due to an overlap in Federal funding which accompanied the ADMS Block Grant when it was authorized in 1981, and to increases in State appropriations. However, a FY 1985 survey of the States conducted annually by the National Association, in cooperation with the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), documents serious unmet service needs. In the FY 1985 survey, which was conducted last November, ninety-eight percent of the State respondents indicated that there were major needs identified by the State planning process for which resources were not adequate to meet those needs.

While the alcohol and drug abuse services system has survived the past five years, a maintenance budget has not allowed the services system to respond to the new demands being placed on it by the general public, ever-increasing numbers of driving while intoxicated offenders, growing numbers of individuals dependent on cocaine and other drugs and the homeless population. In addition, in 1985 and 1986 we have been experiencing increasing demands for treatment from members of the intravenous (IV) drug using population who have learned of the dramatic rise in the numbers of AIDS cases that are directly related to IV drug use. Additional resources are needed to ensure that all IV drug users are informed of this dangerous AIDS - IV drug use connection and offered appropriate services.

The States have clearly assumed a major role in the provision of resources for alcohol and drug abuse treatment and prevention services. While State monies represent close to 50 percent of the total funds allocated for alcohol and drug prevention and treatment programs, Federal sources provide 20 percent of the resources and county/local sources another 10 percent. This funding mix, however, is different from State to State. In the Chairman's State of Kentucky, Federal ADMS Block Grant monies represent over one-third of the resources available to programs which receive State alcohol and drug agency administered funds. It is apparent, however, that the alcohol and drug services system relies on the mutual support of Federal, State and local government grants.

LACK OF APPROPRIATE REIMBURSEMENT BY MEDICARE AND MEDICAID

While most other traditional and non-stigmatized types of health-care services are typically eligible for reimbursement by private and public health insurance programs, it is the exception rather than the rule for alcohol and drug abuse services to be covered by many of these third-party programs. Private third-party payors are beginning to recognize the wisdom of providing appropriate alcohol and drug abuse benefits and many large employers are insisting that appropriate alcohol and drug abuse benefits be included in the health insurance provided for their employees. These employers recognize the cost savings aspect of alcohol and drug abuse treatment since it enhances productivity and reduces other health care utilization. Unfortunately, too many of these available benefits are limited to hospitalization which generates excessive costs and often denies more appropriate and effective treatment. The Federal government's public health insurance programs are the worst offenders of excessive spending for hospitalization and are lagging far behind the private sector in providing more cost effective benefits for alcohol and drug abuse treatment.

A demonstration project recently concluded in six States by the Health Care Financing Administration (HCFA) has been examining the feasibility and cost-effectiveness of extending Medicare and Medicaid reimbursement for non-hospital alcohol treatment services. Results from the States participating in the study, Connecticut, Illinois, Michigan, New Jersey, New York and Oklahoma, have repeatedly documented the cost-effectiveness and extensive savings of this reimbursement policy. For example, the State of Illinois found that the provision of non-hospital alcoholism treatment services to 176 Medicaid clients resulted in substantial "net savings" to the State. Savings were defined as the difference between the estimate of what health care costs would have been without treatment for alcoholism and what health care costs actually were. Net savings were defined as savings less costs of providing alcoholism treatment. Net savings to the State of Illinois for these 176 Medicaid clients were estimated to be approximately $151,000 in FY 1983 and in excess of one-half million dollars for the period of July, 1983 - March, 1984. As we recommended last year, NASADAD urges the Subcommittee members to support an extension of non-hospital alcohol and drug treatment services to Medicare and Medicaid clients in all States. This extension of benefits will result in significant, overall cost savings to the Federal government.

The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 required the Secretary of the Department of Health, Education, and Welfare to "develop and conduct comprehensive health, education, training, research and planning programs for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholics". Yet, 16 years later, the Federal Government has yet to provide reimbursement for these services in a cost-effective and appropriate manner through the Federal Government's primary health care programs for the poor, aged and disabled. Your support for and recognition of these services would end this costly discrimination against persons who are dependent on alcohol and other drugs.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH SERVICES BLOCK GRANT

If the Medicare and Medicaid programs provided appropriate services, the ADMS Block Grant could concentrate on providing services for those who have inadequate health insurance and who are not eligible for Medicaid and Medicare. As it now stands, ADMS Block Grant funds are being seriously depleted by serving Medicare and Medicaid eligible recipients and cannot as a result meet other service needs. Even if the ADMS Block Grant appropriation was equal to the full authorization level for FY 1987 - $576 million - the total amount of funds would continue to be far inadequate until we correct these deficiencies in the Medicare and Medicaid programs.

The Administration has requested $490 million for the ADMS Block Grant program in FY 1987, the same amount appropriated by the Congress in FYs 1985 and 1986. The FY 1986 appropriation, however, was recently reduced by $21 million in response to the Balanced Budget and Deficit Reduction Act for a final FY 1986 appropriation of $469 million.

Because of the allocation formula change provided in the ADMS Block Grant authority by the Alcohol, Drug Abuse and Mental Health Amendments of 1984 only one-half of the States have received an increase in their ADMS Block Grant since FY 1984. Those States which benefited from the allocation formula change received an increase in FYs 1985 and 1986 over their FY 1984 award level. Those same States, however, were required to absorb the full brunt of the $21 million reduction required by Gramm-Rudman-Hollings due to a hold harmless provision in P.L. 98-509 which protected those States that had not received an increase since FY 1984.

It should also be emphasized that in addition to the allocation formula change, P.L. 98-509 requires States to spend an amount equal to five percent of the TOTAL ADMS Block Grant award on the expansion of alcohol and drug services to women, regardless of whether the State received an increase in the award for FY 1985. These new conditions are causing difficulties for the services systems in almost all of the States and U.S. Territories.

The President's budget request for the ADMS Block Grant in FY 1987 represents a 43 percent reduction from the FY 1980 level for Federal alcohol and drug abuse programs. If the Members of the Subcommittee were to appropriate the full amount authorized for the ADMS Block Grant program in FY 1987 -- $576 million; the alcohol and drug abuse portion would represent $292 million. This amount remains substantially below the FY 1980 appropriation of $332 million, but it would provide some welcome relief to the alcohol and drug abuse treatment and prevention services system and assist in meeting the ever-increasing demand for services. We therefore, strongly encourage the Members of the Subcommittee to appropriate $576 million for the ADMS Block Grant program in FY 1987.

NIAAA AND NIDA

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) are the lead Federal agencies responsible for supporting research directed at improving our understanding of the causes and consequences of alcohol and drug abuse and addiction and the development of improved prevention and treatment techniques. They are also responsible for the development of national public service campaigns, data collection, technical assistance and information dissemination.

Research and Research Training

Recent advances in research have confirmed that heredity is a major contributing cause of alcoholism in a large proportion of cases and found similarities between the neurochemical anomalies induced by alcohol and those that occur in some individuals displaying violent behavior or depression. Additional research is needed to identify the subtypes of alcoholism which will lead to improved diagnosis and treatment of the immune system, including cell-mediated immunity, which protects against viral infections.

Over the last decade, NIDA has been recognized by the scientific community for its unprecedented advances in our understanding of the mechanisms of brain functioning and its relationship to drug use, advances which have pushed drug abuse research into the forefront of the neurosciences. Psychological and social research is also yielding needed information about incidence and use patterns, associated behavioral changes, and longterm mental and behavioral effects of drug use.

The October, 1984 Institute of Medicine (IOM) Report on the progress and prospects of the ADAMHA research programs highlights exciting research being undertaken by both NIAAA and NIDA and emphasizes that the level and range of opportunities for productive alcohol and drug research have never been greater. One of the report's major recommendations calls for an annual commitment to alcohol and drug research of $100 million per Institute for research and research training and yet the President's budget request for NIAAA research and research training is only $58 million. For the NIDA research and training efforts, the Administration's request is $74.4 million.

Despite major scientific advances and the identification of critical and immediate research opportunities, the President's FY 1987 budget request for NIAAA research of $56.6 million would necessitate a dramatic drop in support for new and competing grants; in the average costs of these grants; in the non-competing regular research grants; and in research contracts, impede essential epidemiological and treatment research.

NASADAD encourages the Subcommittee Members to appropriate $72 million for the NIAAA research budget. An appropriation at this level would:

- Provide a 15 percent increase in the number of research project grants supported by the NIAAA. This should be followed by incremental increases of approximately 15 percent each year through 1990. At this rate of growth, the number of grants funded by 1990 would still be under 500, a modest level in comparison to other health research Institutes.

- Award 116 new and competing investigator-initiated project grants at IRG recommended levels an increase of 16 percent over the number awarded in 1986.

- Provide funds to allow at least 3 grants to be awarded with an average cost of at least $.5 million. This will allow NIAAA to award several costly treatment and clinical projects.

- Allow expansion of other research mechanisms in order to achieve and maintain program balance. Thirty percent of extramural research funding needs to be provided to mechanisms other than regular research project grants.

- Expand the existing centers and fund 2 new centers on alcohol and high risk populations, and alcohol and immunology.

- Allow the Alcohol Intramural Research Program to expand its level of effort; limited increases in personnel, equipment, and facility renovations should be provided to take advantage of its newly established clinical program located on the NIH campus.

- Provide opportunities to initiate additional high priority Intramural Research through the purchase and operation of dedicated NIAAA instrumentation, e.g., high resolution spectrometer. The availability of the technology to intramural scientists will allow researchers to use NMR spectroscopy to directly examine the metabolism of organs known to be affected by alcohol, particularly the heart and liver.

For NIDA, the President's budget request for FY 1987 would reduce the monies requested for new and competing grants and reduce the total number of these grants from 131 in FY 1986 to 117 in FY 1987. A 60 percent reduction in the research centers' budget is also proposed.

As an alternative budget proposal, NASADAD recommends that the Subcommittee appropriate $90.5 million for the NIDA research program. In contrast to the President's request, our request would permit:

- Award of approximately 150 new and competing research grants providing needed resources for basic and clinical research programs;
- Award of 3 new Clinical Research Centers at responsible funding levels (at least one of which will focus on cocaine treatment), and ongoing funding for competing renewals and continuation;
- Funding of costly, but necessary, large prevention strategy research grants;
- Full indirect cost reimbursement for regular research grants;
- Support of 3 new epidemiology contracts, including a junior high school student survey to assess the incidence and prevalence of drug use among this population surveys to fill in gaps in current information on the use of drugs by ethnic minorities and school dropout populations;
- Full operation of the often-postponed Adolescent Clinical Treatment Research Program. The program is dependent on the . Intramural Research Program's capability to expand its patient treatment capacity from 10 to 32 beds.

We are also recommending increases in research training funds at NIDA and NIAAA to ensure a continued investment in developing trained scientists to study the important areas of drug and alcohol abuse. The current levels of support for research training at these Institutes are unconsciousably low. The President's budget proposes only $1.3 million for NIAAA (63 trainees) and $1.4 million for NIDA (68 trainees). We recommend a substantial increase in funding for these programs commensurate with the needs in the field. It is essential to establish a base of trained personnel capable of carrying out future high quality research in these overlooked but highly prevalent tragic disorders. Our recommendation for NIDA research training is $1.9 million (100 trainees) and for NIAAA research training $1.8 million (80 trainees).

Clinical Training

Included in the FY 1986 appropriations bill was an appropriation of $1 million for the restoration of the NIAAA and NIDA clinical training programs that were dismantled in 1982. We are extremely appreciative of your recognition of this vital program and encourage you to appropriate, at a minimum, $1.0 million per Institute for these programs in FY 1987. The States and the private sector have not been able to assume funding for the national training activities previously supported by Federal funds and require assistance. It should be remembered that the alcohol and drug abuse field have more recovering people, minorities and non-degreed staff than many of the traditional health fields and we need support for the training of our care personnel.

We would also encourage that these monies be directly appropriated to NIAAA and NIDA, rather than being included as part of the NIMH clinical training budget and that the focus of the program be expanded to include training for non-medical personnel including alcohol and drug abuse counselors and social workers.

Prevention and Knowledge Transfer

Perhaps one of our greatest concerns this year, has been the disproportionate reductions in the prevention and knowledge transfer activities of the Institutes under the Gramm-Rudman-Hollings scenario. These activities are mandated by the Congress and located within NIAAA and NIDA's direct operations line time along with personnel and procurement costs. While we are sensitive to the personnel and procurement needs of the Institutes, we and the general public are dependent on the public service campaigns, technical assistance and information dissemination activities carried out by the Institutes with monies located in the direct operations line item. The States, in particular, rely on the Institutes assistance in coordinating and supporting prevention activities on a national level.

Our recognition of the need to protect the prevention and knowledge transfer monies is based on the fact that when the 4.3 percent reduction mandated by the Gramm-Rudman-Hollings balanced budget legislation was applied to the direct operations line item, personnel and procurement activities were protected while NIDA's technical assistance, printing budget and prevention programs were reduced by 20 percent and NIAAA's by an equal or greater amount. It is our understanding that the NIAAA clearinghouse contract will be reduced by approximately 25 percent as a result of the 4.3 percent reduction in the direct operations line item.

We propose that either a separate line item, for prevention and knowledge transfer activities be provided as recommended by the NIDA Advisory Council at its January, 1986 meeting, or that the conference report accompanying the appropriations bill specifically direct the Institutes to refrain from reducing the prevention and knowledge transfer activities by an amount greater than the reduction incurred by the other activities supported by the direct operations line item. We have already lost one-fifth of these important activities at NIDA and NIAAA.

UNIFIED BUDGET REQUEST FOR ADAMHA PROGRAMS

NASADAD has joined 41 other national alcohol, drug abuse and mental health associations in the development of a unified budget request for the ADAMHA programs. This document was developed in response to our deep concern over the inadequacy of the President's proposed FY 1987 budget for ADAMHA. A copy of this document is provided as an attachment to my formal statement for your careful review and consideration. The funding recommendations included in the budget document correspond with those presented in NASADAD's formal statement.

CLOSING REMARKS

In closing, I would like to reinforce my earlier comments that alcohol and drug abuse take an enormous toll on our society, both in economic and human terms. The current treatment system is struggling to survive, operating under a 45% reduction in Federal support at a time that increased public awareness of alcohol and drug abuse problems is placing ever greater demands on the treatment and prevention services network. The ADMS Block Grant must be appropriated at its full authorization level of $576 million in order to meet current service needs and make up for the reduction incurred by treatment and prevention programs since 1982. It is also time that the Federal government's Medicare and Medicaid programs recognized the value, necessity and cost-savings of alcohol and drug treatment on health care costs and provided adequate reimbursement for services in less costly, non-hospital settings.

In addition, the two Federal Institutes designated with the responsibility to provide us with new knowledge and information on the extent, consequences, treatment and prevention of these problems are operating under significant strain. According to the experts, the opportunities for research in these areas have never been greater. However, the Institutes, as the services systems, are facing severe reductions in their research programs.

The prevention and knowledge transfer activities of the Institutes must also be protected by either the formation of a separate line item or Congressional direction before these activities are completely eliminated.

Thank you for the opportunity to appear before you today.

FY '87 COALITION APPROPRIATIONS RECOMMENDATIONS FOR ADAMHA

Alcohol and Drug Problems Association of North America
American Academy of Child Psychiatry
American Association for Partial Hospitalization Legal Action Center
American Association of Chairmen of Departments of Psychiatry
American Association of Directors of Psychiatric Residency Training
American Association for Counseling & Development
American Council for Drug Education
American Hospital Association
American Medical Society on Alcoholism and Other Drug Dependencies
American Mental Health Counselors Association
American Nurses Association
American Occupational Therapy Association
American Orthopsychiatric Association
American Psychiatric Association
American Psychological Association
American Society for Adolescent Psychiatry
Americans for Substance Abuse Prevention
Association for the Advancement of Psychology
Association for Specialists in Group Work
Association of Labor-Management Administrators and Consultants on Alcoholism
Association of Psychiatric Outpatient Centers of the Americas
CareInstitute
Child Welfare League
Corporation for the Advancement of Psychiatry
Council of Graduate Departments of Psychology
International Association of Psychosocial Rehabilitation Services
Mental Health Law Project
National Alliance for the Mentally Ill
National Association for Alcoholism and Drug Abuse Counselors
National Association for City Drug and Alcohol Coordination
National Association of Alcoholism Treatment Programs
National Association of Private Psychiatric Hospitals
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Association of State Mental Health Program Directors
National Council of Community Mental Health Centers
National Council on Alcoholism
National Mental Health Association
The American College of Neuropsychopharmacology
The Committee on Problems of Drug Dependence
Therapeutic Communities of America

OVERVIEW

This document reflects the views of a coalition of organizations deeply concerned with the inadequacy of the President's proposed fiscal 1987 budget on people with mental disorders, alcoholism, alcohol or drug abuse problems, and with the impact of the President's proposed rescissions of fiscal 1986 spending. The coalition believes that funding for programs under the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) is now far too low, and has for some time been critically short of the need. This view is supported by the Institute of Medicine, in its report "Research on Mental Illness and Addictive Disorders: Progress and Prospects":

> "Mental disorders and addictive states, especially when severe or chronic, cause personal, economic, and social upheaval both for afflicted individuals and for those close to them. In the United States alone, conservative estimates suggest that mental disorders and addictions directly afflict 30 to 45 million people and cost $20 billion annually in direct health-care expenditures. They contribute especially to morbidity, using such measures as utilization of long-term care and Social Security Disability, and the indirect costs to society, including lost productivity, social services, and crime control. Overall, yearly direct and indirect expenses total an estimated $185 billion. Costs are especially high for the severe mental problems of childhood, which can produce lifelong debilitation. These data suggest that economic consequences of the disorders under the ADAMHA purview are comparable to those for heart disease and cancer."

Our coalition has analyzed the President's budget and is united in its opposition to these proposals. The President's budget focuses on large reductions in many domestic spending programs, including those of importance to mentally disabled people and those addicted to alcohol and drugs. Some of the most devastating proposals for the ADAMHA budget are the termination of demonstration programs, clinical training initiatives, state planning activities and the elimination of the new Protection and Advocacy program. In addition, the President proposes reductions in research and research training, at a time in our history when significant expansion in these areas is essential to enable us to capitalize on new knowledge about the brain and behavior.

While acknowledging the need to address budget deficits, our coalition does not believe human service programs, including those of ADAMHA, should bear the heavy burden of further cuts. These programs have been pared to the bone already, and Congress must look at alternative means to control the federal deficit.

The recommendations on the following pages would enable the federal government to maintain a leadership in support of ADM programs . . . Research, Services and Training.

We urge the Congress to seriously consider our recommendations as the FY 1987 appropriations process moves forward.

SUMMARY OF RECOMMENDATIONS

ADAMHA

(in $ millions)

	FY '86* Congressional Appropriation	FY '87 Current Services	FY '87 President's Budget	FY '87 Our Proposal
Research				
(NIMH)	214.0	237.0	199.0	272.0
(NIDA)	74.0	82.6	73.0	90.5
(NIAAA)	57.0	63.7	56.6	72.0
Research Training	21.0	22.7	18.5	31.3
Clinical Training				
(NIMH)	19.0	20.0	0	26.0
(NIDA)/(NIAAA)	1.0	1.0	0	2.0
Block Grant	490.0	525.0	490.0	576.0
State Planning	0	0	0	5.0
Community Support	12.5	11.0	0	20.0
Protection/ Advocacy	10.0	10.5	0	10.5
Direct Operations	62.5	63.0	58.5	65.6

* prior to Gramm-Rudman sequestration

NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) RESEARCH
(in millions of dollars)

FY '86	Current Services FY '87	President's FY '87	Our Proposal FY '87
$214.0*	$237.0	$199.0	$272.0

(* 204.7 after GRH)

The National Institute of Mental Health (NIMH) is this country's major funding source for research related to mental health. The President's Commission on Mental Health found that 90% of funding for mental health research emanates from the public sector. The 1984 Institute of Medicine report, "Research on Mental Illness and Addictive Disorders: Progress and Prospects," further documents the dependence of mental health research on NIMH funding and dramatically demonstrates how support for research on mental disorders has never achieved a reasonable level, especially when compared with support for comparably costly physical disorders. The historically inadequate levels of funding apply to support of the research infrastructure (i.e., such investigator-initiated programs as research centers, research scientist and career development awards) as well as traditional project grants and other research activities.

Scientific opportunities over the past few years have been particularly evident in the neurosciences, including behavioral research on understanding attention and memory, basic biochemical processes, the interactions between physiological processes and behavior underlying mental disorders and the effects of stress on the family unit. However, the President's budget seriously cuts back on even the current level of NIMH support nationally, sending a negative signal to research scientists as well as to individuals with mental disorders and their families, at the very time when substantial progress is being made.

Areas of research in which there are substantial opportunities and extensive needs include: application of newly available techniques in neuroscience and molecular biology to the study of schizophrenia and other psychotic disorders; the role of the brain and behavior in relation to Alzheimer's disease and other mental disorders; the study of the mental health consequences of child abuse and neglect; application of the recent advances in psychobiology and behavioral research to disorders of children and adolescents; continued development of new treatments for depressive and manic depressive disorders; early intervention and preventive strategies in a wide range of mental disorders; and the study of the interaction of behavioral and biomedical factors in AIDS.

In contrast to the President's request, our proposal would permit:

- Award of approximately 425 new and competing extramural research project grants, providing needed resources for priority initiatives in schizophrenia, elderly and child mental disorders, and the behavioral factors in the development and treatment of AIDS;

- Award of at least 4 new Research Centers in priority areas such as schizophrenia, child disorders, aging, and neurosciences and funding for the 6 competing renewals terminated under the President's budget;

- Critical increased funding for other research mechanisms such as Small Grants, Research Scientist Development Awards, (which particularly focus on establishing a pool of talented younger investigators) as well as Cooperative Agreements and Contracts;

- Adequate personnel and equipment for the Intramural Research Program.

NATIONAL INSTITUTE ON DRUG ABUSE (NIDA) RESEARCH

(in millions of dollars)

FY '86	Current Services FY '87	President's FY '87	Our Proposal FY '87
$ 74.0*	$ 82.6	$ 73.0	$ 90.5

(* 70.8 after GRH)

The National Institute on Drug Abuse (NIDA) is the lead Federal agency responsible for supporting research directed at improving our understanding of the causes and consequences of drug abuse and developing improved drug abuse prevention and treatment techniques. The Institute of Medicine's landmark study highlights exciting research undertaken by NIDA and describes extremely promising areas of new research. The panel reported, "Until recently most attempts to control drug abuse have been legal efforts to block drug production or to punish users or dealers; research advances offer the promise of other, one hopes more effective, approaches to the problem. Successful attacks on drug abuse most likely will come from knowledge of the complex biological, psychological, and social factors that reinforce drug-seeking and drug-using behavior despite its dangerousness and destructiveness to users, members of their families, and society".

Over the last decade, NIDA has been recognized by the scientific community for its unprecedented advances in understanding the mechanisms of brain functioning and its relationship to drug use, advances which have pushed drug abuse research into the forefront of the neurosciences. Psychological and social research is yielding needed information about incidence and use patterns, associated behavioral changes, and longterm mental and behavioral effects of drug use. Such data are vital for effective treatment and educational efforts. Tragically, the President's budget would not allow NIDA to maintain even its current level of effort.

In contrast to the President's request, our proposal would permit:

- Award of approximately 150 new and competing research grants providing needed resources for basic and clinical research programs;
- Award of 3 new Clinical Research Centers (at least one of which will focus on cocaine treatment), and funding for competing renewals and continuations;
- Support of costly, but necessary, prevention strategy research grants;
- Support of 3 new epidemiology contracts, including a junior high school student survey to assess the incidence and prevalence of drug use among this population and surveys to assess the use of drugs by ethnic minorities and school drop-out populations;
- Full operation of the often-postponed Adolescent Clinical Treatment Research Program. The program is dependent on the Intramural Research Program's capability to expand its patient treatment capacity from 10 to 32 beds.

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM (NIAAA) RESEARCH

(in millions of dollars)

FY '86	Current Services FY '87	President's FY '87	Our Proposal FY '87
$ 57.0*	$ 63.7	$ 56.6	$ 72.0

(* 54.5 after GRH)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports research aimed at developing knowledge to improve treatment and ultimate prevention of alcohol abuse and its tragic consequences. NIAAA's research program offers tremendous opportunities for major advances in medical services that can reduce these burdensome problems. Each problem requires different treatment modalities, most of them symptomatic and empirically derived. As more is learned about biological substrates and psychosocial aspects of alcohol abuse and alcoholism, it may be possible to design more specific and rational interventions.

In 1984, the Institute of Medicine (IOM) recommended that the research and research training budget of the NIAAA be dramatically increased while noting that the level and range of opportunities for productive alcohol research have never been greater. Recent advances in research have confirmed that heredity is a major contributing cause of alcoholism in a large proportion of cases and found similarities between the neurochemical anomalies induced by alcohol and those that occur in some individuals displaying violent behavior or depression. Research is needed to identify the subtypes of alcoholism which will lead to improved diagnosis and treatment and to an understanding of how alcohol affects every major component of the immune system, including cell-mediated immunity, which protects against viral infections.

Despite major scientific advances and the identification of critical and immediate research opportunities, the President's FY '87 budget request would necessitate a dramatic drop in support for new and competing grants, non-competing regular research grants, and research contracts, in the process impeding essential epidemiological research and treatment research.

In contrast to the President's request, our proposal would permit:

- Award of approximately 116 new and competing research project grants at council-approved levels, providing needed funding for such priority areas as the fetal acohol syndrome and alcohol's effect on neurobiological processes;

- Full funding and expansion of existing research centers and the award of 2 new centers focused on high-risk populations and immunology;

- Expansion of the Intramural Research Program. Limited increases in personnel, equipment, and facility renovations should be provided to take advantage of its newly established clinical program located on the NIH campus;

- Expansion of the Research Scientist Development Awards with special emphasis on clinical researchers.

ADAMHA RESEARCH TRAINING
(in millions of dollars)

FY '86	Current Services FY '87	President's FY '87	Our Proposal FY '87
$ 21.0*	$ 22.7	$ 18.5	$ 31.3

(* 20.1 after GRH)

Research training grants and fellowships are integral parts of the overall behavioral and biomedical research programs in this country. The number of research trainees supported by ADAMHA has declined steadily over the past several years. This consistent decrease makes it increasingly difficult to ensure an adequate supply of well-trained biological and behavioral researchers in the important areas of mental health, drug abuse and alcohol abuse. If the present promise and pace of ADAMHA research is to be realized and maintained in coming decades, we must work to assure the future availability of the research manpower upon whom the nation will depend for the success of that effort.

Our recommendation for research training is based on the current research opportunities and needs of the field, and is consistent with the recommendations made by the Institute of Medicine (IOM) in its 1985 report, "Personnel Needs and Training for Biomedical and Behavior Research." The report states that, "a cadre of able investigators already is studying many aspects of mental and addictive disorders, but rapid evolution in the biobehavioral sciences constantly creates demands for new types of specially trained researchers, often without diminishing the continued needs of existing specialties." Current research areas of identified special need include those related to childhood mental disorders, alcoholism and chronic mental illnesses such as schizophrenia.

At NIMH, the number of research trainees supported has declined over the past six years from a high of 1,350 to a projected 751 under the Administration's FY '87 budget proposal. Our alternative recommendation would support 1,200 research trainees at NIMH, a number consistent with the levels recommended in the IOM report. As the IOM suggests, emphasis needs to be placed on attracting talented physicians, and members of other clinical disciplines to enter research careers, and also to increase support of predoctoral awards to avoid a projected shortage of future behavioral and biomedical research scientists. These funds would also support expansion of shortterm training programs to attract students in the health professions into research careers at early stages.

We recommend increases in research training funds at NIDA and NIAAA to ensure a continued investment in developing trained scientists to study the important areas of drug and alcohol abuse. The current levels of support for research training at these institutes are unconscionably low. The President's budget proposes only $1.3 million for NIAAA (63 trainees) and $1.4 million for NIDA (68 trainees). Our alternative proposal includes a substantial increase in funding for these programs commensurate with the needs in the field. We recommend $1.9 million (100 trainees) for NIDA research training and $1.8 million (80 trainees) for NIAAA research training.

CLINICAL TRAINING
(in millions of dollars)

	FY '86	Current Services FY '87	President's FY '87	Our Proposal FY '87
NIMH	$19.0	$ 20.0	0	$ 26.0
NIDA/NIAAA	1.0*	1.0	0	2.0

(* 19.1 after GRH)

The NIMH clinical training program traditionally has been the main source of support for mental health professionals. Funding between 1975-80 averaged around $70 million per year. For the fifth consecutive year the President proposes the termination of this activity which trains psychiatrists, psychologists, psychiatric nurses, social workers, mental health counselors and para-professionals and supports state manpower development. Federal support is still vital, especially in view of unanimous evidence that certain populations and geographic areas are underserved, including enormous numbers of senior citizens, children, jailed populations and chronically mentally ill living in the community for these groups.

According to the Institute of Medicine (IOM) report "Research on Mental Illness and Addictive Disorders," 15% of the population suffers from serious mental disorders at any given time, but less than one-third of these people will receive any form of treatment. The magnitude of the problem indicates that this is clearly a matter of national concern that cannot be adequately addressed at the state and local level. Training professionals to meet these needs is a long-recognized federal concern.

We endorse Congress' continued direction of NIMH (through report language) to focus the program on these targeted areas. Studies by the General Accounting Office (GAO) and NIMH indicate that where trainees obtain their education and work experience influences where they decide to practice. We also support Congress' call for an equitable distribution of funds amongst the disciplines. An appropriation of $26 million for NIMH clinical training would assure needed continuation support and modest new growth to better implement the important Congressional initiatives. Central to our concern is a dearth of other funding sources to meet these needs.

The Alcohol, Drug Abuse and Mental Health Amendments of 1984 (P.L. 98-509) authorizes grants to support the training of health professionals in the identification and treatment of alcohol and drug abuse problems. Prior to being defunded in 1982, the Clinical Training programs in alcohol and drug abuse were implemented through grants to States, National Training Centers, and Career Development and Management Internship Programs. Contrary to the Administration's expectations, an adequate pool of alcohol and drug abuse program personnel has not developed as neither the States nor the private sector have assumed responsibility for the funding of training programs. In fact, many training programs have been dismantled at a time when the need for more competent drug and alcohol abuse personnel is being clearly demonstrated.

We feel that in order to provide competently trained core personnel in the areas of mental health, alcohol and drug abuse the NIMH Clinical Training Program should be appropriated at $26 million and the NIDA and NIAAA Clinical Training Programs should each receive a minimum appropriation of $1 million.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT & STATE PLANNING

(in millions of dollars)

	FY '86	Current Services FY '87	President's FY '87	Our Proposal FY '87
Block Grant	\$490.0*	\$ 525	\$490.0	\$576.0
Planning	0	0	0	5.0

(* 469 after GRH)

The ADAMH Block Grant is the foundation of funding for alcohol and drug abuse and community mental health services, helping to forge a partnership among federal, state and community-level providers. In 1981, alcohol, drug abuse and mental health categorical programs were consolidated into the Alcohol, Drug Abuse and Mental Health Block Grant as part of P.L. 97-35. The Block Grant is essentially two block grant programs within one authority, with different requirements and provisions for alcohol and drug abuse programs and community-based mental health services. The 1984 Amendments established a 10% set aside for seriously mentally disturbed children based on evidence that 7-10 million children are in need of mental health services. An additional 5% set-aside for alcohol and drug-related services to women has had a dramatic impact on these states that have not had an increase in their state award since 1984 resulting, in some cases, in the elimination of services to other populations.

The President's request of \$490 million for the ADAMHA Block Grant (considering the impact of inflation since 1985) would result in a decrease of \$39.0 million in the purchasing power for existing services. This budget would not allow states to respond to the crisis of the large and growing number of people with chronic mental illness who are homeless; would not allow states to meet the demand for alcohol and drug abuse services by the general public, DWI affenders, cocaine addicts and IV drug users who have been alerted to the spreading threat of AIDS among the IV populations; and would not continue the direction begun in 1984 to bring all states up to the appropriate share of funding. The President's request to eliminate the important State Planning initiative stifles the incentive to move states to develop needed comprehensive community care services for citizens with severe mental illness.

We recommend an appropriation of \$576.0 million for the ADAMHA Block Grant and \$5 million for the state interagency planning grants. A significant portion of the increased funds would be used by states to provide community mental health intervention services for people with prolonged mental illness who are homeless, including outreach services to locate this population both in the streets and in shelters. The alcohol and drug abuse monies would be used to support the basic service system and expand services to those underserved populations identified by the states and communities. Our recommendation for coordinated state planning would enable the continuation of planning initiatives in 7 states and the funding of new planning initiatives in several more states. These initiatives, conducted at high levels of state government, specifically address coordinated interagency planning so as to more effectively provide the entire range of services required by people who are seriously mentally ill living in the community. In FY 1985, 7 states received initial funding for such planning initiatives. While such planning normally requires a 5-year time frame, the Administration's failure to request funding for this program has resulted in a policy decision that the 1985 awards made in 1986 will be one-year grants.

State	FY 1986 $490 Million	Coalition's Recommendation: FY 1987 Increase	 $575 Million
Alabama	$ 9,328,000	$ 1,608,200	$ 10,936,200
Alaska	2,093,000	137,600	2,230,600
Arizona	9,004,000	1,109,400	10,113,400
Arkansas	6,385,000	963,200	7,348,200
California	48,406,000	8,488,200	56,894,200
Colorado	7,004,000	1,075,000	8,079,000
Connecticut	6,985,000	1,014,800	7,999,800
Delaware	1,428,000	206,400	1,634,400
Florida	24,033,000	3,861,400	27,894,400
Georgia	11,093,000	2,210,200	13,303,200
Hawaii	2,827,000	352,600	3,179,600
Idaho	1,660,000	387,000	2,047,000
Illinois	19,574,000	3,973,200	23,547,200
Indiana	19,524,000	2,064,000	21,588,000
Iowa	2,936,000	1,066,400	4,002,400
Kansas	3,962,000	842,800	4,804,800
Kentucky	4,551,000	1,479,200	6,030,200
Louisiana	5,665,000	1,677,000	7,342,000
Maine	3,733,000	447,200	4,180,200
Maryland	4,871,000	1,470,600	6,341,600
Massachusetts	18,240,000	1,969,400	20,209,400
Michigan	15,948,000	3,285,200	19,233,200
Minnesota	4,933,000	1,470,600	6,403,600
Mississippi	5,165,000	1,126,600	6,291,600
Missouri	9,804,000	1,840,400	11,644,400
Montana	2,153,000	309,600	2,462,600
Nebraska	2,683,000	576,200	3,259,200
Nevada	2,897,000	301,000	3,198,000
New Hampshire	3,844,000	344,000	4,188,000
New Jersey	20,647,000	2,468,200	23,115,200
New Mexico	4,934,000	550,400	5,484,400
New York	40,097,000	6,063,000	46,160,000
North Carolina	10,963,000	2,408,000	13,371,000
North Dakota	1,163,000	240,800	1,403,800
Ohio	23,585,000	3,930,200	27,515,200
Oklahoma	7,775,000	1,195,400	8,970,400
Oregon	5,670,000	989,000	6,659,000
Pennsylvania	25,114,000	4,308,600	29,422,600
Rhode Island	4,417,000	344,000	4,761,000
South Carolina	6,684,000	1,333,000	8,017,000
South Dakota	3,100,000	266,600	3,366,600
Tennessee	7,798,000	1,866,200	9,664,200
Texas	21,446,000	5,598,600	27,044,600
Utah	3,778,000	662,200	4,440,200
Vermont	3,313,000	197,800	3,510,800
Virginia	8,384,000	1,969,400	10,353,400
Washington	8,977,000	1,505,000	10,482,000
West Virginia	4,292,000	791,200	5,083,200
Wisconsin	5,263,000	1,728,600	6,991,600
Wyoming	768,000	172,000	940,000
D. C.	2,467,000	189,200	2,656,200
Guam	536,000	34,400	570,400
Puerto Rico	6,875,000	1,169,600	8,044,600
Virgin Islands	1,113,000	34,400	1,147,400
Others	112,000	51,600	163,600
TOTAL	$490,000,000	$ 85,724,800	$ 575,724,800

NIMH COMMUNITY SUPPORT PROGRAM AND OTHER SERVICES DEMONSTRATIONS
(in millions of dollars)

FY '86	Current Services FY '87	President's FY '87	Our Proposal FY '87
\$ 12.5*	\$ 11.0	0	\$ 20.0

(* 11.9 after GRH)

The National Institute of Mental Health (NIMH) Community Support Program (CSP) focuses on the unique problems of individuals with chronic mental illness who are trying to make lives for themselves in the community. Originally designed to serve adults, the program was expanded three years ago to serve children and adolescents who have severe emotional problems. CSP was again expanded in 1984 when P.L. 98-507 charged NIMH with serving homeless and elderly adults with chronic mental illness. Funds are used to stimulate better planning and coordination of state and local programs by providing technical assistance and community based service programs. Success is reflected in the increasing focus of state and local communities on the needs of these individuals, the substantial drop in hospitalization of the target population, the success of demonstration projects and the number of applications to NIMH which continue to exceed available resources.

The President's request is to provide no funds for FY '87. If enacted, it would wipe out this small but effective initiative. The lack of adequate community resources to serve those with chronic mental illness has led to a crisis in many states and contributed to the growing population of homeless people and an alarming growth in the number of teenagers and children, as well as adults, who are committing suicide. Failure to fund CSP demonstration projects will severely curtail the ability of states to overcome the most intractable problems related to this population whose need for assistance grows each year and to better serve deinstitutionalized adults, homeless people with chronic mental illness, children and adolescents with severe emotional problems, and individuals with chronic mental illness who move in and out of the hospital and jail systems. We recommend \$20 million for the Community Support Program and other service demonstrations for FY '87.

The recommended amount is necessary: (a) to continue and expand NIMH services research initiatives on problems of homeless people with chronic and other mental disorders and to continue local demonstration projects for providing services for this hard to reach group (\$5 million); (b) to continue demonstration projects on the more effective use and coordination of services for elderly persons who suffer from serious mental disorders (\$1 million); (c) to plan and initiate demonstration projects to coordinate services for people with mental disorders who are in the jail and hospital systems (\$2 million); (d) to continue state-wide CSP initiatives for adults who have chronic mental illness (\$4.5 million); (e) to continue and expand the Children and Adolescent Service System Program (CASSP) for children with serious emotional problems (\$6.2 million); (f) to continue to conduct important services system research (\$1.3 million). The need for more effective planning, development, coordination, outreach and evaluation of services is not only critical, it is mandatory.

MENTAL HEALTH PROTECTION AND ADVOCACY PROGRAM
(in millions of dollars)

FY '86	Current Services FY '87	President's FY '87	Our Proposal FY '87
$ 10.0*	$ 10.5	0	$ 10.5

(* 9.5 after GRH)

The House and Senate conferees have agreed to (S. 974), the Mentally Ill Persons Protection Act which establishes a protection and advocacy system for persons who have "significant mental illness or emotional impairments" and are residents of facilities providing them with care or treatment. Facilities are not further defined in the bill, but according to the accompanying report include: public and private hospitals, nursing homes, group homes and board and care facilities.

The House version of the legislation passed by a vote of 290-84 on January 30. The Senate passed its bill on June 30, 1985 by voice vote. Given the overwhelming bi-partisan support, the President is expected to sign the bill when it reaches his desk in April.

The program provides funds on a formula grant basis to expand the existing state Protection and Advocacy (P&A) System for the developmentally disabled to investigate complaints of abuse and neglect affecting mentally ill people and pursue administrative, legal and other appropriate remedies. The P&A System in each state must have an advisory board of persons expert in mental health issues, with a majority representation of people who have received or are receiving mental health services and their families. The FY '86 Labor, HHS and Education Appropriations Act included $10 million ($9.57 million after G/R/H sequestration). The President's budget proposes to rescind the FY '86 appropriations and requests no funds in FY '87. We recommend that Congress reject the FY '86 rescission proposal and appropriate $10.5 million for FY '87, the authorization level in the House bill.

Hearings conducted by Senator Weicker in 1983 and 1985 and a comprehensive study undertaken by the staff of his Subcommittee on the Handicapped uncovered a pattern of patient abuse and neglect in public psychiatric hospitals of our nation. Similar problems have been revealed in nursing homes and community facilities caring for persons with mental disorders.

Unfortunately, many of the residents of these institutions have been abandoned or have outlived their closest family members. Their well-being has become dependent, in part, on the availability of trained advocates, knowledgeable about the operations of instutions and the rights of residents, who can investigate and remedy through legal and other advocacy techniques situations of gross negligence and abuse.

With the enactment of S. 974, a P&A System will be developed nationwide, building on the experience of the P&As and providing cost-effective and nonduplicative services. The FY '86 monies, when available, will be used for planning, start-up, and training outreach and direct services. Fiscal year 1987 will be the first full year of the program's implementation and must be funded at the full authorization level.

ADAMHA DIRECT OPERATIONS AND STAFFING

(in thousands of dollars)

	FY '86		Current Services FY '87		President's FY '87		Our Proposal FY '87	
	FTE	Amount	FTE	Amount	FTE	Amount	FTE	Amount
NIMH								
Direct Operations	364	$34,675	364	$34,074	364	$31,749	364	$34,074
Research	526		526		526		538	
NIDA								
Direct Operations	175	$16,307	175	$16,976	175	$15,983	180	$18,000
Research	85		85		85		93	
NIAAA								
Direct Operations	110	$11,658	110	$12,135	110	$10,876	125	$13,632
Research	92		92		92		100	

Direct operations activities provide program management of the ADAMHA's research, training and services activities. Adequate staffing and program support are critical for the proper development and implementation of the three Institutes' programs. We are concerned that over the past several years there has been a gradual erosion of funds available for activities which are essential to the support of research in particular. To make full use of its resources, the ADAMHA enterprises must maintain stewardship and oversight over the expenditure of its funds; provide opportunities for its own staff to stay in touch with new developments in the field; and have the ability to disseminate the results of its work. Curtailment of essential travel, publications, and communications expenses can result in the waste or misdirection of tens of millions of dollars.

In contrast to the President's proposal, our proposal would:

- Restore the AIDS research program to the ADAMHA. This program is proposed for transfer to the PHS under the 1987 budget.
- Provide NIMH with needed funds for site visitation and technical assistance to extramural research grantees; critical data gathering activities in the field of mental health statistics and research on delivery systems and health care financing; technical assistance to states and local communities for dealing with the problems of the chronically mentally ill, mentally ill homeless, seriously disturbed children and adolescents and mental disorders affecting the elderly; and research dissemination activities.
- Restore funds to NIDA for prevention and communications activities disproportimately reduced under the recent sequestration order.
- Provide NIAAA with increased funds to maintain program growth and restore postponed initiatives including the National Clearinghouse for Alcohol Information, and high-priority Homeless, Prevention and AIDS-related activities.

FRIDAY, MARCH 14, 1986.

POPULATION ASSOCIATION OF AMERICA

WITNESS

BETH SOLDO, ASSOCIATE PROFESSOR, DEPARTMENT OF DEMOGRAPHY, GEORGETOWN UNIVERSITY

Mr. NATCHER. Our next witness is Dr. Beth Soldo. We will be pleased to hear from you at this time.

Dr. SOLDO. Good morning, Mr. Conte, Mr. Natcher.

My name is Beth Soldo and I am an Associate Professor in Demography at Georgetown University. I am here this morning to speak on behalf of the appropriation request for the National Institute for Child Health and Human Development for fiscal year 1987.

I am representing the Public Affairs Committee of the Population Association of America. This is an organization of national and international demographers, economists, geographers and sociologists. PAA represents close to 3,000 researchers whose studies range from identifying the determinants of child bearing decisions to exploring the impact of energy costs on interstate migration. While PAA members receive research support from many sources, an important funding source for demographic research comes through the Center for Population Research at NICHD.

Demographic and behavioral aspects of population research provide unique information that assists national, State and local governments in making oftentimes difficult allocation decisions. The size, age composition, geographic distribution of the population are of critical value to policymakers.

The unexpected explosion of births that spawned the so-called baby boom is a prime example of a demographic event that from its onset was certain to reverberate through society. Baby-boomers crowded maternity wards, the public school system, boosted enrollments in colleges and universities and taxed the ability of the labor force to absorb cohorts of unprecedented size.

Passing through its life cycle, the baby-boom generation strained existing infrastructures, forcing first their rapid expansion, and then their contraction. Had public policymakers been more attentive to demographic research, these population dynamics could have been anticipated, planned for.

By studying trends and variations in fertility, demographers are working towards a clearer understanding of the factors that affect child-bearing, the social and economic consequences of changes in birth rates and changing family structure. All of these trends have important policy implications.

Researchers are concentrating special efforts on the problem of adolescent pregnancy by studying the fertility behavior of teenagers and by examining the consequences of adolescent childbearing both for the individuals involved and for State and Federal programs and expenditures.

Demographic studies also document the changing structure of the American family by exploring factors such as the timing of first marriage, the incidence of divorce, living arrangements, remarriage trends and morbidity/mortality patterns. In its scrutiny of the socioeconomic implications of population growth, decline and change, demographic research provides invaluable analyses for effective planning in both the public and private sectors.

The major source of Federal funding for demographic research is within NICHD—the Center for Population Research, the Demographic and Behavioral Sciences Branch. This Branch supports a program of research which responds to changing social conditions as well as to an evolving knowledge base.

Currently a major focus of the program is the examination of family and household structure and its impact on the wellbeing of children. Preliminary findings of one project indicate that there are significant differences in the development and well-being of children across different types of families.

Another research effort underway is examining contraceptive use among adolescents—who uses it and who uses it well. Other research projects related to adolescent pregnancy have studied the relationship between postponement of childbearing and the resulting benefits to individuals and society. Related research is assessing the effects of teen parenthood on school-related accomplishments of the young mother and on emotional adjustment of the offspring. The work of this branch is an important complement to the total research mission of the National Institute of Child Health and Human Development.

For fiscal year 1986, of the $322 million appropriation for NICHD, the Center for Population Research received approximately $106 million. One-sixth of the Center's budget supports the Demographic and Behavioral Sciences Branch.

For fiscal year 1987 the President has requested $309 million for NICHD in toto. This reduced request comes at a time when NICHD is in the forefront in studying some of the most critical issues facing our country: low birth weight, birth defects and genetic disease, mental retardation, unintended pregnancies, and development of new, safer and more acceptable contraceptives.

The Public Affairs Committee of the Population Association of America urges this subcommittee to support the original request of the Institute to the Department of Health and Human Services—$376 million for fiscal year 1987.

This will put NICHD on a parity with other Institutes in relation to the funding rate for competing research grants. For fiscal year 1985 NICHD had an award rate of 28 percent, meaning only 28 percent of those projects which were approved were actually funded.

This was the lowest of any institute at NIH. The revised budget for fiscal year 1986 again puts NICHD at the lowest award rate of any institute at a time when NICHD has experienced a significant increase in the number of grants approved.

An appropriation of $376 million would raise the NICHD award rate to 34 percent which is comparable to the other institutes at NIH. This appropriation level would also restore training positions to the fiscal year 1985 level, permit funding for two additional centers focusing on prevention of premature births and would continue to support the institute-wide initiatives on low birth weight and infant mortality and contraceptive development.

Our recommendation for this appropriation level reflects our support for the full range of research activities at the Institute. We believe the breadth of research encouraged by NICHD promotes a comprehensive understanding of critical child health and development issues and provides the framework for developing primary health intervention strategies.

The activities at NICHD not only reduce the pain associate with childhood disease and dysfunction, but also provide a cost-effective investment in the future of our children.

Thank you very much.

Mr. NATCHER. Thank you very much, Dr. Soldo.

Mr. CONTE. Very good statement, Doctor.

I would like to ask you do you, have some of those demographic studies that you can send me?

Ms. SOLDO. I will be happy to give them to you. Perhaps the easiest thing to do is give you the summary of the research program currently supported and then you can check with individual investigators for more details.

Mr. CONTE. Fine.

Mr. NATCHER. Thank you very much.

FRIDAY, MARCH 14, 1986.

NATIONAL COUNCIL OF TEACHERS OF MATHEMATICS

WITNESS

JOE CROSSWHITE, PRESIDENT

Mr. NATCHER. Our next witness is Dr. Crosswhite. We are glad to have you back before the committee again and we will be pleased to hear from you.

Dr CROSSWHITE. Mr. Chairman, Mr. Conte, I am here as president of the National Council of Teachers of Mathematics. Ours is a professional society of over 62,000 members representing mathematics teachers at all levels of education.

We also represent 197 local councils of teachers across the United States and Canada. All of these councils are devoted to the improvement of mathematics education in our schools.

I thank you for inviting me here today to testify in favor of continued support of Title II of the Education for Economic Security Act. Over the past several years a series of crisis reports including "A Nation at Risk", "Educating Americans for the Twenty-first Century", and others, have pointed out the shortage of qualified mathematics teachers in our schools.

Over three years ago as part of a national response to this critical condition, Congress passed the Education for Economic Security Act. With the signing of that legislation, the slow process of regulation writing, State-wide needs assessment and planning and submitting applications began.

Only during this school year has the program—authorized three years ago—really touched classroom teachers.

Gentlemen, the problems that caused Congress to pass that legislation are still with us. There are simply not enough qualified mathematics and science teachers in the classrooms. The situation may be even more severe than it appears.

The shortage is frequently obscured. Superintendents do not leave classrooms unattended. Many are required to staff mathematics and science classes with teachers who are at best marginally qualified in their disciplines.

A recent survey in the State of Iowa, for example, revealed up to 50 percent of the mathematics openings last year were filled by the reassignment of teachers from other subject areas. In my own State of Ohio, certification regulations permit teachers prepared for elementary school to teach any subject through grade eight. Most of those teachers have very limited training in mathematics—possibly only a single college-level course and yet it is not uncommon to see good second grade teachers being transferred to teach mathematics at grade 7 and 8, so those teachers prepared to teach mathematics at grades 7 and 8 can be moved into the high school to fill vacancies.

In some States the demands of high-tech industries for persons talented and trained in science and mathematics have created unusually severe shortages, sometimes as a result of those industries having siphoned off many of the most highly qualified teachers. This has resulted in a variety of emergency measures.

In New Jersey an alternative route to certification has been devised for persons with training in the discipline but with little or no training in the professional aspects of teaching. In California, where many teachers hold general secondary school teaching certificates, very short retraining programs have been initiated to move teachers from other fields to science and mathematics.

In Los Angeles, For example, this past summer many teachers were retrained during one four-week period to move into the science and mathematics classroom. We do not question the sincerity, commitment or professionalism of those cross-over teachers, but they do need help.

They need help not because they are inherently poor teachers, but because they may be teaching in a new field at a new level or with inadequate preparation in the discipline or in the teaching of that discipline.

In this current era of educational reform, even experienced and well-trained teachers need programs of staff development. Teaching, as is true of other professions, should be a life-long learning experience. Experienced teachers need help in adjusting to new tools of instruction such as calculators and computers, they need help in their efforts to implement curriculum change that relates to these new technologies, and they need help in responding effectively to the vast number of students who must now continue their study of mathematics because of increased high school graduation requirements.

Recently, the Department of Education released a compilation of research on education entitled "What Works." Cited in this study are results from the Second International Mathematics Study that indicate that in 1982 the mathematics achievement of both our eighth-grade students and the top five percent of high school seniors studying our most advanced mathematics courses we offer was at or near the bottom as compared to other industrialized nations in the study.

That fact is ominous. The United States simply cannot remain competitive if we do not educate our young people better in mathematics.

Mathematics is a discipline basic to all the sciences. Indeed, science stands on the shoulders of mathematics. Mathematics must be well taught in elementary schools and in middle and junior high schools if we are to build an effective base for more advanced instruction in the high schools and colleges.

Although there has been an unprecedented response toward educational excellence in the States and in local schools since 1982, it would be naive to pretend that the problem is now well in hand. We have only just begun to close the educational gap between the United States and the rest of the industrialized world.

Title II was designed to assist in reducing the shortage of qualified teachers of mathematics and science and to improve the capabilities of those teachers already in the schools. It provides funds that are distributed by the States to local school districts and to colleges and universities to improve the knowledge base and the teaching abilities of teachers.

This process is just beginning. In a review of the applications for funding under this title, the Department of Education estimates that the program this school year will impact on ten million teachers and students, at all levels. That is a lot of impact for a relatively small amount of money.

There are other benefits of this program. It provides evidence that national leadership does not need to be accompanied by Federal control. The leadership and stimulation provided by this program has caused State and local educators to emphasize teachers' improvement and program development.

Although the exact dimensions of the teachers' development programs vary from area to area, the fact that there is now a widespread effort to improve both in-service and preservice teacher education using a national approach can have a very positive effective. Only teachers can implement educational reform. There is no such thing as a teacher-proof curriculum.

If a teacher could be replaced by a computer, they should be.

Federal leadership has increased the awareness of the critical role teachers play. States and local districts have followed this leadership with new incentives to attract and retain qualified teachers.

It would be a shame if conflicting signals were sent to local schools and State officials by the withdrawal of Federal support of such a basic program. The Federal Government should sustain, and even extend, such leadership activity.

Relatively small amounts of Federal money committed to a program of in-service training will not in itself solve the problems confronting school mathematics. The problems are not that simple. But a sustained program over a number of years can make a difference. To halt the program now, in what is really just its formative stage, could send a signal of despair to the nation's schools.

Although we are here today to testify for the continuation of support for the science and mathematics education program funded under Title II of the Education and Economic Security Act, this is only one way in which national leadership is needed.

More work needs to be done to recruit new mathematics teachers and to retain the many well-qualified teachers already in our schools. We need a nationally coordinated program of research and development to understand better the factors that put us in the non-competitive situation in which we find ourselves as revealed in the Second International Mathematics Study and to design programs of reform that will help to remedy that situation.

These are national problems, and they require national initiatives. Even to address the training or retraining problems associated with science and mathematics teaching will require more than the single piece of legislation we have addressed today. But the alternative offered by the Administration weakens more than it strengthens the potential for impact.

Mr. Chairman, that is like hunting big game, hunting with bird shot. You might hit something, but you seriously reduce the probability of having an impact on anything.

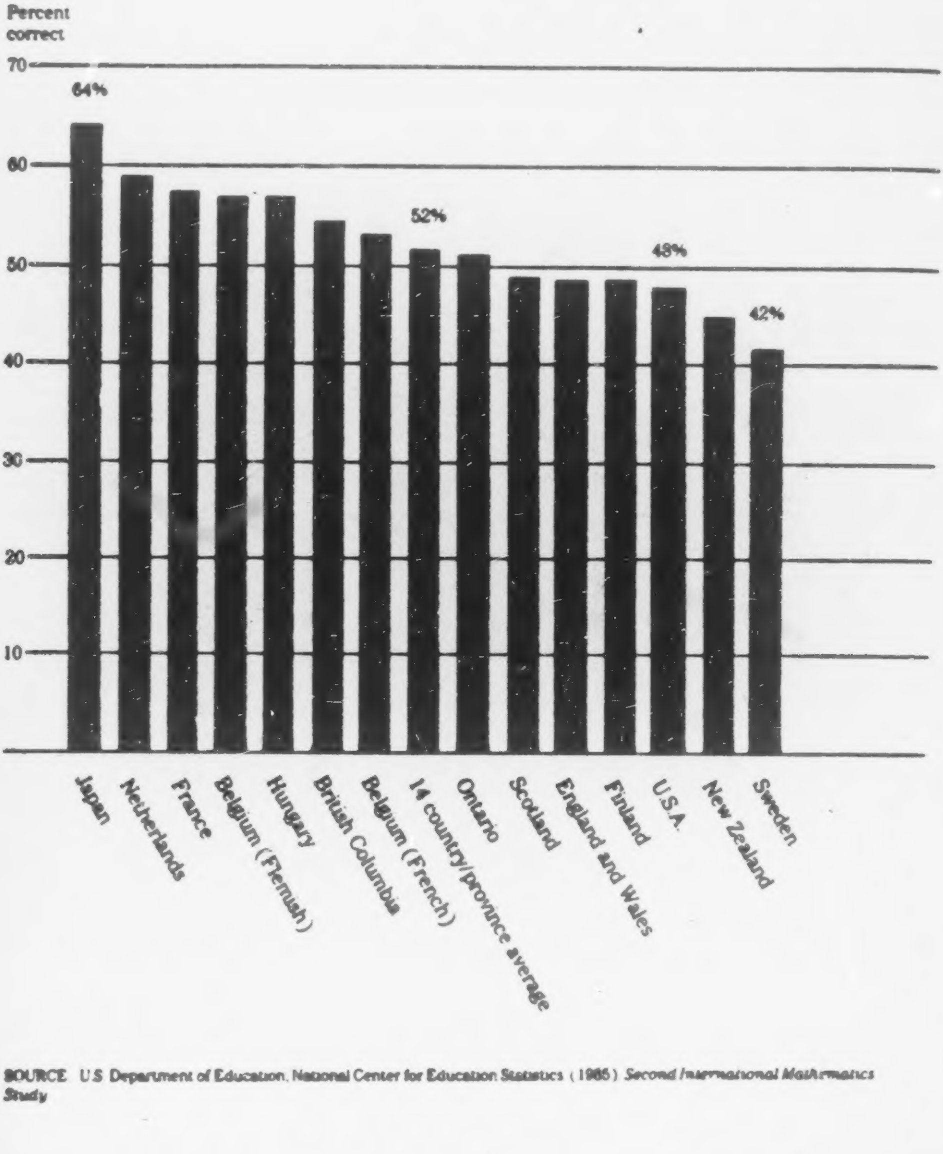
For all these reasons and because the alternative legislation has not yet been enacted, we request that you fund the current legislation so that the efforts begun this year can continue.

The National Council of Teachers of Mathematics and its affiliated councils hope that this subcommittee will support Title II of the Education for Economic Security Act.

Thank you.

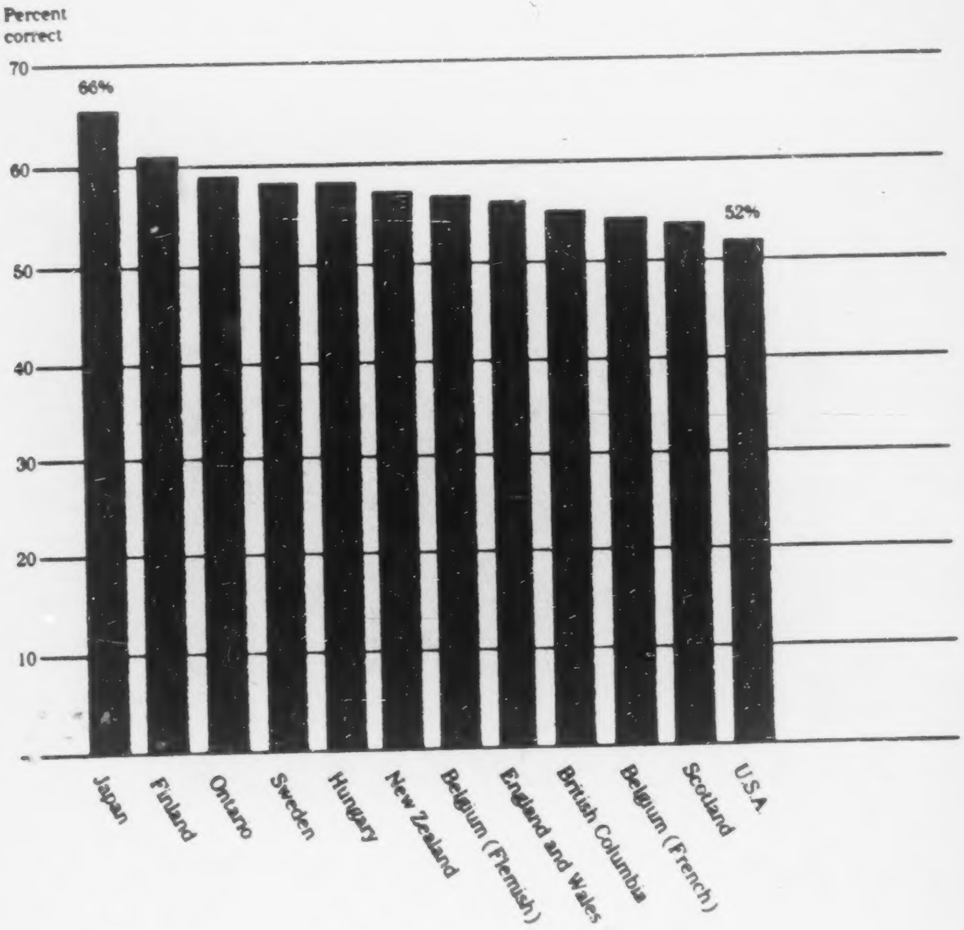
[The attachments of the statement of Mr. Crosswhite follow:]

Average Mathematics Score for Students in the Eighth Grade: 1981–82



SOURCE: U.S. Department of Education, National Center for Education Statistics (1985) *Second International Mathematics Study*

Score in Algebra and Calculus for Top 5 Percent of 12th Graders: 1981–82



SOURCE U.S. Department of Education, National Center for Education Statistics (1986) *Second International Mathematics Study*

Mr. **Natcher**. You have made an excellent statement, Mr. Crosswhite.

The committee will now recess until one o'clock.

MONDAY, APRIL 28, 1986.

CENTERS FOR DISEASE CONTROL

WITNESS

WENDY J. WERTHEIMER, DIRECTOR OF PUBLIC AND GOVERNMENT AFFAIRS, AMERICAN SOCIAL HEALTH ASSOCIATION

Mr. NATCHER. Our first witness this afternoon is Ms. Wendy J. Wertheimer. Come right around. We are glad to have you back before before the committee.

Ms. WERTHEIMER. Thank you, Mr. Chairman. It is nice to be here again.

More than 12,000,000 Americans each year acquire a sexually-transmitted disease (STD). Yet, in the last several years, the STD control program at CDC has suffered a cut in funds, a reprogramming, a hiring freeze, the Gramm-Rudman sequestration, and the direct diversion of funds from the STD program to AIDS activities.

Although this committee requested that CDC submit in writing any intended redirection of funds to AIDS, no written notification has ever been sent to the committee.

The diversion of resources is also in direct violation of authorizing legislation for the STD program. Depending on who you talk to at CDC, last year between 15 and 30 percent of funds appropriated to the STD program were diverted to AIDS.

The result of that reprogramming has been significant increases in the STD rates in this country. This is in no way to imply that any less money should be going to AIDS.

I would like to endorse the increases for AIDS others will speak to today, but the STD program cannot be the source of those funds.

We are already seeing the consequences of doing that. The two diseases that we are intensively working on through the STD Program are syphilis and gonorrhea. In the last year, when funds were being redirected away, gonorrhea increased almost 7 percent. Gonorrhea had been decreasing almost every year in the last decade.

Syphilis rates are coming down, due largely to the change in behavior in gay men, but syphilis in babies has increased 100 percent in the last year.

Gonorrhea was further complicated by gonorrhea cases that are not treatable by antibiotics. Just in the last year, there has been a 70 percent increase in penicillin-resistant gonorrhea.

According to CDC, chlamydia affects almost 5,000,000 Americans every year. It affects men, women and babies. More than 100,000 babies are affected by chlamydia each year, and it can lead to ectopic pregnancy and infertility in women and possibly even infertility in men. Yet the CDC program has done very little on chlamydia, and it has no money to do anything more.

Herpes affects at least 20,000,000 Americans, and has virtually no control program at CDC. Papilloma viruses, which have a relationship to cervical cancer, have almost no funds being accorded them at CDC.

Chlamydia is a disease I am most concerned about this year. Five million Americans are affected. It is treatable and diagnosable. A new diagnostic test that is inexpensive is now available. Yet CDC does not have the funds even to do the diseases that it must continue to do, syphilis and gonorrhea.

CDC estimates $50,000,000 would be necessary for every State to be capable of diagnosing and treating chlamydia. More than 150,000 women will become infertile this year because of sexually-transmitted diseases.

There will be over 75,000 ectopic pregnancies this year, 75,000 babies who will die. Ectopic pregnancy is also the leading cause of maternal death in black women, so those ectopic pregnancy rates also represent maternal death as well as fetal death.

A lot of that tragedy could be eliminated by controlling chlamydia. As I said, $50,000,000 would be necessary to do that.

Since 1980, when we first diagnosed AIDS, there have been over 600,000 women rendered infertile by sexually-transmitted diseases. 6,000 babies were born with herpes, half have died. 600,000 ectopic pregnancies occurred since 1980, and half were directly attributable to sexually-transmitted diseases.

More than 50,000,000 cases of STD have occurred since 1980. There is no way the amount of money we have can ever begin to do justice to such a pervasive problem.

We are only addressing syphilis, gonorrhea and AIDS now. All the other diseases are left with no control, no prevention. As we divert more money and more attention away from the STD program to focus on AIDS, we are totally losing control of all the other STD problems. This poilicy is going to haunt us.

I, therefore, would urge the committee to include, first of all, very strong report language concerning the redirection of STD funds.

Secondly, to support whatever levels possible for AIDS.

And thirdly, to provide enough money for the CDC program to initiate national chlamydia control.

Thank you, Mr. Chairman.

Mr. NATCHER. Thank you very much.

[The statement of Ms. Wertheimer follows:]

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TESTIMONY
BEFORE THE
LABOR/HHS/EDUCATION SUBCOMMITTEE
OF THE
HOUSE APPROPRIATIONS COMMITTEE

REGARDING
FY 1987 APPROPRIATIONS FOR
THE DIVISION OF
SEXUALLY TRANSMITTED DISEASES
OF THE CENTERS FOR DISEASE CONTROL

Presented by
Wendy J. Wertheimer
Director of Public and
Government Affairs

April 23, 1986

VENEREAL DISEASES RESEARCH FUND · VD NATIONAL HOTLINE HERPES RESOURCE CENTER (formerly HELP)

Mr. Chairman, on behalf of the Board of Directors and members of the American Social Health Association, one of the oldest non-profit organizations in the country, I appreciate this opportunity to speak to you on behalf of Fiscal Year 1987 funding for the Division of Sexually Transmitted Diseases of the Centers for Disease Control.

ASHA, founded in 1912, is unique in that we are the only national non-profit organization solely focused on the epidemic of sexually transmitted diseases. Our programs include the VD National Hotline, the Herpes Resource Center, the Venereal Diseases Research Fund, as well as professional and public education initiatives.

Mr. Chairman, the federal program of sexually transmitted diseases prevention and control has been devastated over the past few years by the sheer magnitude of the STD problem, a cut in funds, a reprogramming, a hiring freeze, the Gramm-Rudman sequestration, and the direct diversion of funds and personnel to AIDS activities. These events have had a severe impact on the health of our nation, particularly young people, women and their babies.

In hearings before this Committee last year, the Centers for Disease Control testified that, apart from a requested $1.5 million reprogramming from the STD program for AIDS, no further diversion of funds would be necessary. Report language requested written notification to the Committee of any other diversion of funds. Yet by the end of FY 1985 up to 30% of STD funds were being diverted to AIDS, with an average over the year of 15% of the program funds diverted. In addition, 45 FTEs were diverted to AIDS activities.

No written notification of this significant diversion of funds and personnel was ever sent to this Committee. Further, this diversion clearly violates the intent of Section 318 of the Public Health Service Act authorizing the program. That legislation provides that STD funds may be made available to AIDS activities after appropriations for STD grants to states exceed $50 million in FY 1985. One-half of the excess over $50 million can be made available for AIDS. In FY 1986, one-half of the excess over $52.5 million may be made available for AIDS, and in FY 1987, one-half of the excess over $55 million shall be available for AIDS activities. As you well know, Mr. Chairman, funding for grants did not nearly approach the threshholds provided in the legislation.

This is in no way a suggestion that any less funding or attention should be devoted to AIDS. In fact, Mr. Chairman, we support and endorse whatever federal funds are necessary to deal with AIDS. However, this funding and personnel should not be at the expense of a program which must also deal with epidemics which are out of control. The Administration's policy of funding AIDS at the expense of other sexually transmitted diseases is unwise, short-sighted, and dangerous.

CDC estimates that approximately 12 million Americans will acquire a sexually transmitted disease this year — among them 2.5 million teenagers. Through FY 1984 fully 94% of the federal STD control program was devoted to syphilis and gonorrhea control. However, at least 20 organisms are known to cause sexually transmitted diseases, including Chlamydia Trachomatis, herpes simplex viruses, cytomegaloviruses, hepatitis B, human papilloma viruses, and HTLV-III. Infections caused by these organisms have devastating impact on reproductive health, maternal and child health, neonatal health, and neoplasia. Despite dramatic increases in these infections, the only one of these diseases receiving strong federal attention is HTLV-III. Virtually no control effort is taking place for the other diseases, diseases which are not only dangerous but sometimes deadly as well. Tens of millions of Americans are affected by the other sexually transmitted diseases, yet no new initiatives have been undertaken, and the STD program can accord them only minimal attention. Budget constraints have made difficult and terrible choices necessary. We are trading lives for lives.

Gonorrhea: Gonorrhea remains the most commonly reported disease and represents the largest investment of STD control efforts. Reported cases of gonorrhea have been decreasing steadily for most of the past decade. However, in FY 1985, when funds were diverted away from the program, reported gonorrhea morbidity increased for the first time since 1980. Further, in addition to gonorrhea cases increasing by 6.8%, gonorrhea rates increased for the first time in a decade.

Additional obstacles confront efforts to control gonorrhea. From 1979 to 1984 there was a 14-fold increase in gonorrhea resistant to antibiotics. In FY 1985 the number of reported cases of penicillin-resistant gonorrhea increased 70%. Antimicrobial resistance severely hampers efforts to control the disease.

Syphilis: Until 1983 syphilis rates were increasing steadily, however since that time, due to changes of behavior among gay men, rates of primary and secondary syphilis have decreased. However, syphilis remains a problem in the heterosexual community, and with further program diversion the rates of syphilis can be expected to rise once again.

It is extremely distressing to note that although overall syphilis has decreased during the past two years, congenital syphilis has shown a large increase in the past fiscal year. In 1980 congenital syphilis rates reached their lowest point, but since then have steadily risen. In 1985 alone, congenital syphilis in infants increased 70%. Rates of congenital syphilis rose 100% between FY 1984 and FY 1985.

Thus the STD program, which had had some sucess in past years in controlling both syphilis and gonorrhea has now failed to maintain control even of those two diseases in which it has the greatest investment of funds and energies. Yet this program is being further burdened by added responsibility for AIDS surveillance, HTLV-III testing, and health education and risk reduction projects for AIDS. But the program has never received any additional funds to carry out these important functions. These demands have made impossible any progress in the control of other STDs which demand attention and commitment.

Chlamydia: Chlamydia is the most common bacterial sexually transmitted disease in the United States today, causing infections in men, women, and babies. It is several times as prevalent as gonorrhea. CDC estimates that more than 4 million cases of chlamydial infection occur each year. In men chlamydia causes non-gonococcal urethritis. In women, the consequences of chlamydial infection can be devastating, resulting in sterility or ectopic pregnancy. Chlamydia can be passed on to babies of infected mothers, causing eye problems and pneumonia in more than 100,000 infants annually. Pregnant women with chlamydia may have a greater risk of miscarriage or stillbirth. Between 7 and 12 percent of all pregnant women are estimated to be infected with chlamydia.

Diagnostic tests are now available which can detect chlamydia quickly and inexpensively. These tests would permit diagnosis of this hidden epidemic disease which is also treatable and preventable. Yet no national chlamydia control initiative has been possible, due to budget constraints. The President's budget would make such a program impossible. CDC has funded a cooperative agreement and demonstration projects to determine control strategies. It is a tragedy that a disease which affects so many lives, which is largely asymptomatic, but is preventable has not received federal attention because of lack of funds.

Herpes: At least 20 million Americans suffer from genital herpes virus infections, with approximately 600,000 new cases each year. Since 1970, visits to medical practitioners for herpes have increased by more than 1000%. Herpes is particularly difficult for women, for whom the disease appears to contribute to a higher risk of cervical cancer. Herpes can be passed to a baby at birth. Approximately 1200 babies will be born with herpes infections this year. Half of them will die; of those who survive half will suffer permanent neurological damage. The STD program has completed a contract to design a pilot project on neonatal herpes. However, national implementation of this important surveillance network will be impossible under the President's budget. Surveillance of neonatal herpes infection is critical because no national surveillance of herpes in adults exists. In fact, allocations for herpes in the direct operations of the STD program in FY 1985 amounted to only half of the sum allocated in FY 1984.

Human Papilloma Virus Infections: The most common sexually transmitted disease caused by a virus is HPV, which causes genital warts, and is probably the most common of all sexually transmitted diseases.

These infections are very difficult to treat and can be passed on to babies born of infected mothers, sometimes with life-threatening consequences. It is believed that there is a strong association between HPV infection and development of carcinoma of the cervix. So much remains to be learned about this highly contagious infection, yet there is virtually no program effort or education carried out by the STD program about this important disease, and the President's budget will prevent any such initiative.

Ectopic Pregnancy: Rising rates of sexually transmitted diseases have resulted in an epidemic of fetal death, which has gone largely ignored in this country. The number of ectopic pregnancies has quadrupled since 1970. Each of these pregnancies results in the death of the fetus and serious risk to the mother. Ruptured ectopic pregnancy has now become the leading cause of maternal death among black women in America. More than half of these pregnancies are directly attributable to pelvic infection caused by gonorrhea or chlamydia. Rates of gonorrhea are climbing, chlamydia remains uncontrolled, and the budget has decreased. The implications for ectopic pregnancy and fetal death over the next few years are staggering.

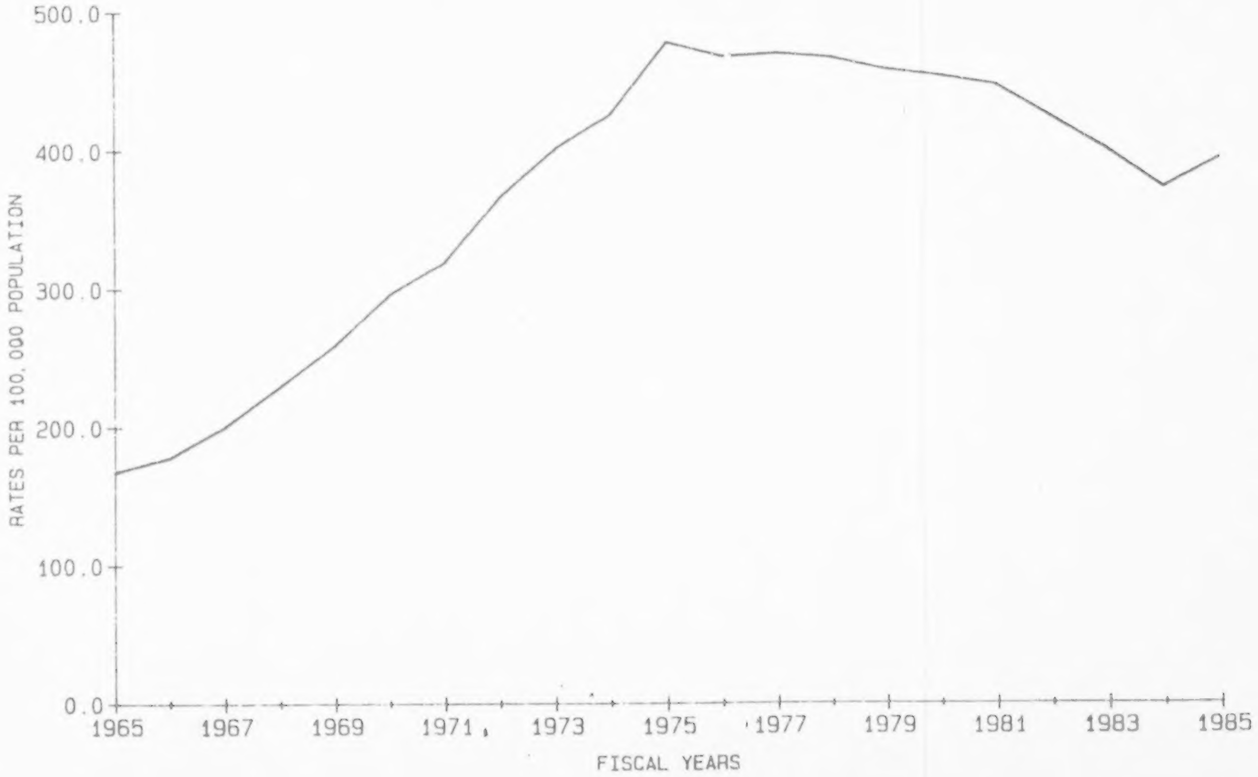
Infertility: A consequence of untreated sexually transmitted disease is involuntary infertility. This year between 110,000 and 150,000 women of child-bearing age will be rendered sterile as a result of these diseases, half of those women are under the age of 25. Sexually transmitted infections are the greatest single cause of unintended sterility in women of child-bearing age. The tragedy is that many of these cases of infertility could be prevented by control of chlamydia. But once the infection has damaged the fallopian tubes it is much harder to treat. The impact of the current budget will be ever-increasing rates of infertility.

Mr. Chairman, the number one public health emergency in this country is sexually transmitted diseases, including AIDS. The failure to recognize the critical importance of dealing with all of these diseases has resulted in disease rates unparalleled in human history. Some STDs may in fact be co-factors in the AIDS epidemic. To focus on one disease at the expense of other STD control has created a tragic situation. Since 1980, when AIDS was first recognized, more than 600,000 women have become sterile from venereal diseases. Since 1980 there have been more than 50 million new cases of sexually transmitted diseases. Since 1980 more than 6,000 babies have been born with herpes, half of them died. Since 1980, more than 400,000 ectopic pregnancies have occurred, at least half of which were caused by sexually transmitted diseases.

We urge the Committee to include strong report language which would prohibit the CDC from diverting funds from the STD program, or any other program, to other activities unless the terms of authorizing legislation are fulfilled. We urge the Committee to provide all necessary funding for AIDS efforts. Others who will testify before you will outline in detail the critical needs for this effort.

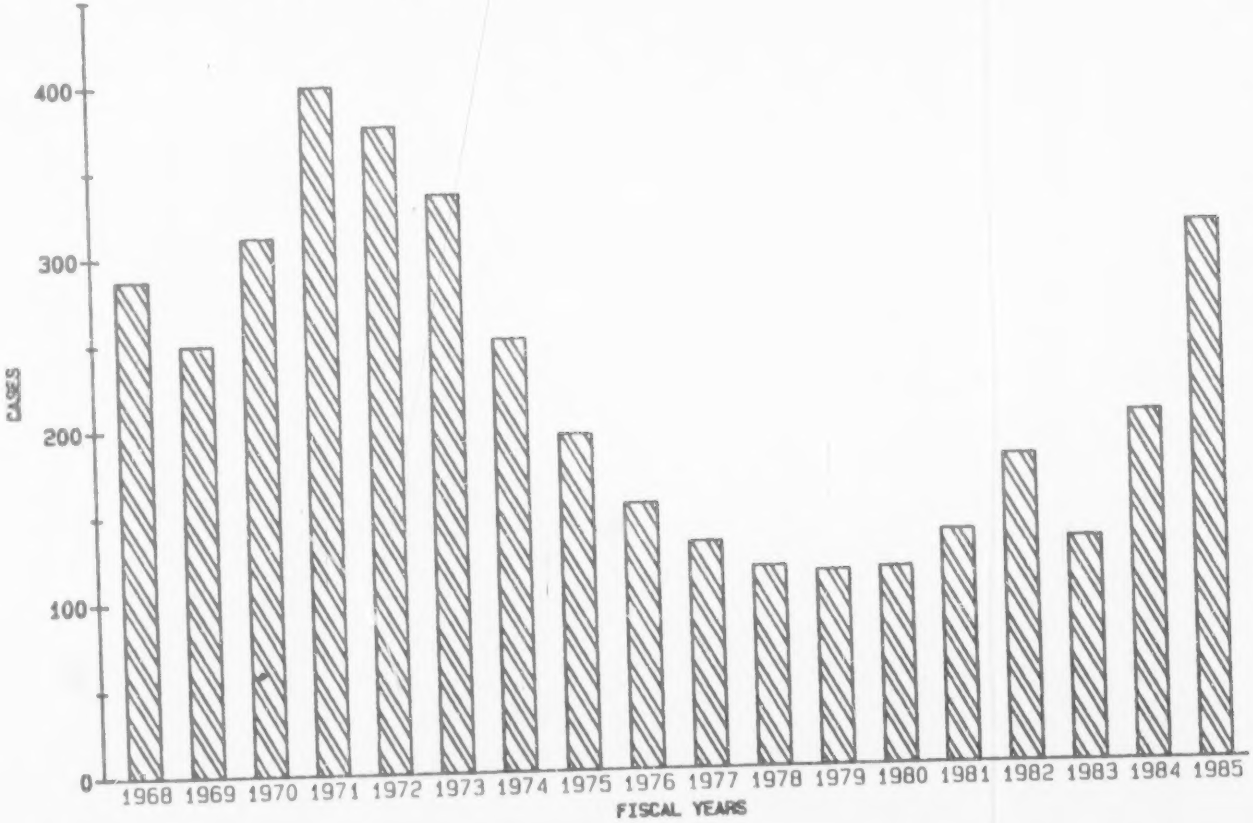
It is estimated that a national prevention and control program for chlamydia would require $50 million in additional funds to the STD program. The prevention and control of chlamydia, a disease affecting more than 4 million Americans each year, with devastating complications if undetected and untreated, must be a top priority for our nation. Chlamydia must become a reportable disease in every state, and each state must have the capability to prevent and control the disease. We urge you to provide this increase. Thank you, Mr. Chairman, for your leadership and for this opportunity to present our views.

GONORRHEA CASE RATES PER 100,000 POPULATION
UNITED STATES, FISCAL YEARS 1965-1985



5d

CONGENITAL SYPHILIS UNDER ONE YEAR OF AGE
UNITED STATES, FISCAL YEARS 1968-1985



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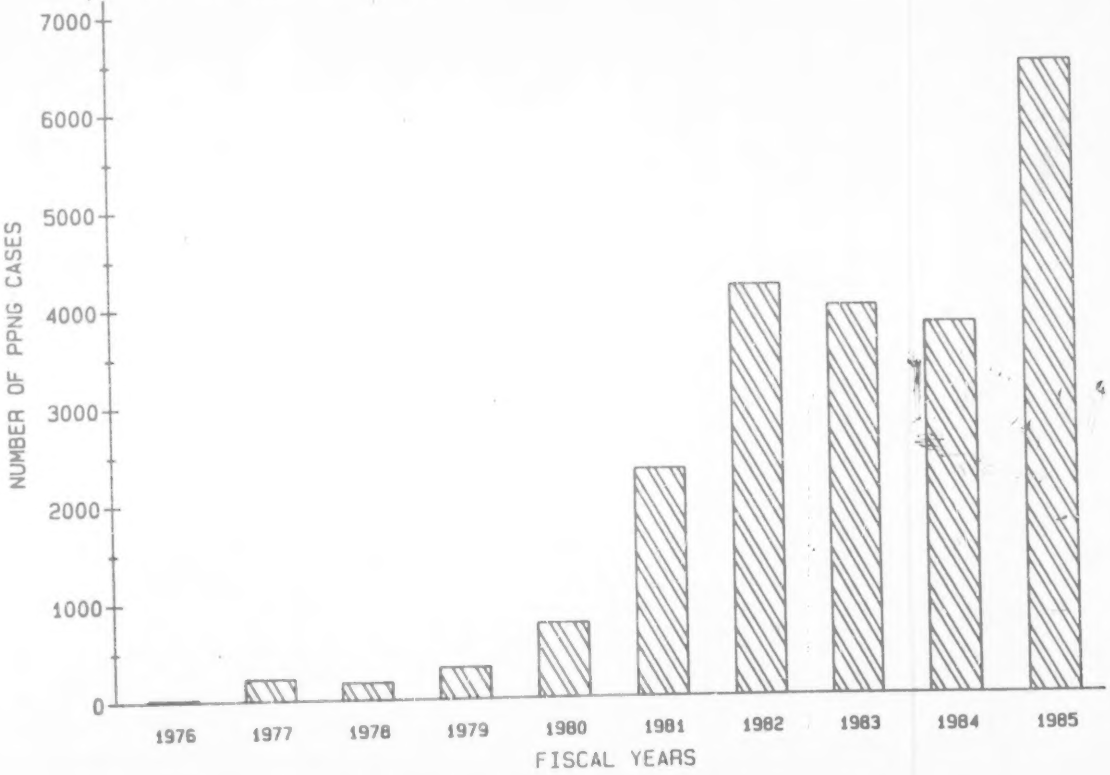
PENICILLINASE-PRODUCING NEISSERIA GONORRHOEAE (PPNG)
NUMBER OF CASES
UNITED STATES (EXCLUDING OUTLYING AREAS): F.Y. 1976-1985

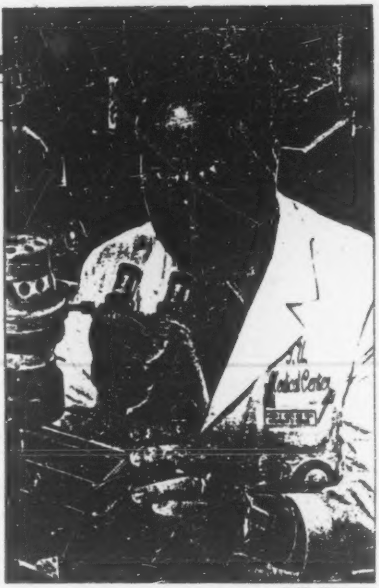


SOCIETY

HEALTH

More Bad News About Sex

Chlamydia strikes nearly 5 million a year



MARY ANN CARTER

Facing an epidemic: *Jones in his laboratory*

In 1977 Debi Milligan, then a graduate student at the University of Massachusetts, was treated for a urinary-tract infection. Three months later the symptoms returned. Thus began a four-year medical odyssey that took Milligan and her husband to 30 doctors and cost $15,000. Along the way she was told she had low-grade appendicitis, premenstrual syndrome and psychological problems. The real villain, however, was chlamydia—a bacterial disease that attacks the reproductive system, often exhibits no symptoms whatsoever and can lead to painful pelvic inflammation, miscarriages and infertility. Although it sounds exotic, an estimated 4.6 million Americans—mostly young heterosexuals—will contract chlamydia this year, making it by far the most prevalent sexually transmitted disease in terms of new cases. "We are in the midst of a chlamydia epidemic," says Dr. Thomas Quinn of the National Institute of Allergy and Infectious Diseases.

One reason the disease is so widespread is that women, and even some doctors, simply haven't considered the possibility of chlamydia (klah-MID-e-ah) when confronted with symptoms such as painful urination, vaginal discharges, abdominal pain and bleeding between menstrual periods. Despite its prevalence, the disease has been eclipsed, both in the medical community and in the public eye, by AIDS, gonorrhea and herpes. Accurate diagnosis has also been complicated by the fact that, until recently, testing for chlamydia was time-consuming, expensive and in some cities simply unavailable. As a result, most victims don't find out they have chlamydia—an "invisible" disease with no early symptoms of its own in some 70 percent of all cases—until the bacterium has done its damage. "Frequently it's when a woman tries to become pregnant and is unable to conceive that chlamydia is discovered to have damaged her Fallopian tubes," says Dr. Robert B. Jones of the Indiana University School of Medicine. In some cases the disease can live undetected in the genital tracts of women and men (who figure in the chlamydia epidemic mostly as carriers and transmitters) for as long as eight years.

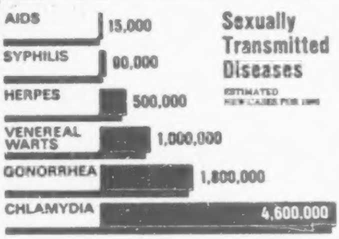
Ectopic pregnancies: When the disease finally manifests itself, it can take a huge physical and emotional toll. Researchers at the federal Centers for Disease Control (CDC) in Atlanta say that chlamydia may be responsible for half of the 1 million annual cases of pelvic inflammatory disease, an often agonizingly painful condition that can lead to infertility. Chlamydia also increases the risk of ectopic pregnancies—when the fertilized egg settles outside the womb—and postpartum infections. "Chlamydia is not connected to its consequences in the minds of most people," says Dr. Eugene Washington, assistant to the director of the CDC's sexually transmitted diseases unit. "People can't see into the hospital when a woman is told she is infertile or follow a couple into therapy or divorce because they cannot conceive." Newborns can be infected if their mothers have chlamydia and, in an estimated 182,000 cases annually, develop eye infections or pneumonia. A recent study at the Universi-

IRA WYMAN

A $15,000 medical odyssey: *Milligan*

An Invisible Disease

Chlamydia, a sexually transmitted bacterial disease that has virtually no early symptoms, attacks the reproductive organs and can cause pelvic inflammation and sterility.



SOURCE: CENTERS FOR DISEASE CONTROL   SCOTT MacNEILL ty of Maryland School of Medicine also indicated that pregnant women with chlamydia may be three times more likely to give birth prematurely. In men, chlamydia can cause infections of the urethra and possible sterility.

One particularly frustrating aspect of the current outbreak, researchers say, is that curing chlamydia is relatively simple and inexpensive—if the disease is caught soon enough. The organism can be killed by a weeklong treatment with either tetracycline or erythromycin at a cost of a few dollars. Doctors and patients alert to the possibility of chlamydia are finding that new types of tests for the disease are also quick and cheap. In the past the only way to diagnose chlamydia was to culture the bacteria, a process that takes several days. In the last few years, however, several tests, costing about $10 to $15, have come on the market. And though doctors advise that such detection methods are not perfectly accurate, the tests are an important advance in treatment of the disease.

'Major problem': Some experts think the most effective way to stop the spread of chlamydia may be to set up voluntary screening of high-risk groups—generally sexually active women with multiple or new partners. (Studies of some college students show that the infection rate on campuses may be as high as 10 percent.) But doctors say that more research is needed, and they worry that AIDS is draining funds. "Chlamydia has been lost in the shuffle," says Washington. "There are quite a few in my field who vociferously complain about the attention AIDS is receiving and lack of attention a condition like chlamydia is receiving." While he calls the public-health consequences of AIDS "tremendous," Washington contends that chlamydia is also a "major, major problem." But defining the size of that problem—the first step in attracting research money—is not easy. Because health regulations in many states do not require reporting cases of chlamydia, the CDC's estimate of 4.6 million cases this year is considered conservative by some researchers, who say that the actual number may be as high as 10 million. Health-care costs related to chlamydia may be more than $1.3 billion, CDC researchers say.

Doctors say patients should take the initiative by being more careful in their choice of sexual partners—and by using barrier methods of contraception, such as the condom and the diaphragm, which are effective in reducing transmission of the infection. Experts also advise women to be tested for chlamydia before they become pregnant. Says Harvard Medical School Prof. Ruth Kundsin: "I think the educated public is the only solution."

Barbara Kantrowitz *with* Tessa Namuth
in New York, George Raine *in San Francisco,*
Mary Hager *in Washington and* Lisa Drew
in Boston

MONDAY, APRIL 28, 1986.

BATTEN'S DISEASE

WITNESS

DR. J. ALFRED RIDER, PRESIDENT, CHILDREN'S BRAIN DISEASES FOUNDATION

Mr. NATCHER. Our next witness is Dr. J. Alfred Rider. Come around, Dr. Rider. We are glad to have you back before the committee, and we will be pleased to hear from you.

Dr. RIDER. Thank you very much.

I am Dr. J. Alfred Rider, President of the Board of Trustees of the Children's Brain Diseases Foundation. It is a pleasure to testify before the House Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies, and support the budget requests of the National Institute of Neurological and Communicative Disorders and Stroke.

I speak today specifically with reference to research funding for Batten's disease. This is a neurological disorder which has an incidence as high as 1 in 12,500 births, similar to other genetic disorders. It is probably the most common neurogenetic storage disease in children.

It manifests itself in previously normal children at the approximate age of 4 to 8 and is characterized by a slow progression of clumsiness, stumbling, failure of vision, seizures, changes in personality and dropping of scholastic grades.

The disease eventually leaves them totally disabled and unable to care for themselves and usually ends in death in the late teens or early 20s and rarely in the 30s.

One of the most promising theories about the disease has resulted from the discovery of an abnormality in the peroxidase enzyme system in the brains of children with Batten's disease. This results in an accumulation of a yellow pigment, ceroid lipofuscin, in the brain cells producing slow destruction and progressive deterioration.

These changes are quite similar to the changes that take place in all brains as they age. Thus, effective treatment for Batten's disease might delay the normal aging process.

In the last year, research has been directed toward improving and expanding upon a blood chemistry test. These studies seem to indicate that there are four sub types of Batten's diseases each having a specific peroxidase enzyme abnormality.

Additional studies have been done on the Kopang dogs and in sheep which have a disease similar to Batten's diseases in humans.

In order to further worldwide recognition of this disease, I presented a paper entitled Batten's disease at the age pigments conference in Italy in June 1985. The proceedings of the conference will soon be published by NVU Science Press, Amsterdam.

Research is the only way to solve this disease and prevent the devastating tragedy in families who have children so afflicted and effect tremendous savings to society as a whole.

The cost of care for each child is enormous and may be as high as $100,000 or more per year. Thus, 10 children such as these would cost more per year than the funds we are requesting.

Once the exact nature of this defect is established, then full effort will be devoted to prevention and treatment. In addition to genetic counseling, therapy will be directed towards enzyme replacement and/or treatment with anti-oxidants.

The Children's Brain Diseases Foundation is doing the best it can to stimulate research on Batten's disease. For example, we are in the process of assisting with the development of two Batten's disease centers, one at the University of Indiana and one at the Institute for Basic Research in Developmental Disabilities in New York.

Unfortunately, our abilities to raise money from private sources are limited, and the major monies must come from the NIH. There are over 35 principal investigators from major universities, medical centers and institutes throughout the world interested in various phases of research pertaining to Batten's disease. These researchers are in dire need of monies to continue their work.

We have always supported the budget presented by the National Institute of Neurological and Communicative Disorders and Stroke. We were very pleased that the committee recommended an appropriation of $428,517,000 for fiscal year 1986, which represents an increase of $32,858,000 over fiscal year 1985.

However, in spite of wording in the 1986 House appropriations bill, namely: "The committee reiterates its concern about research on Batten's disease, and requests that the Institute actively solicit applications of quality for research on Batten's disease", very little money has been spent by the National Institute of Neurological and Communicative Disorders and Stroke on Batten's disease.

I have personal knowledge of only one grant being approved for research on Batten's disease at a very modest level. The title of the grant is "Lipofuscinogenesis in the Retinal Pigment Epithelium."

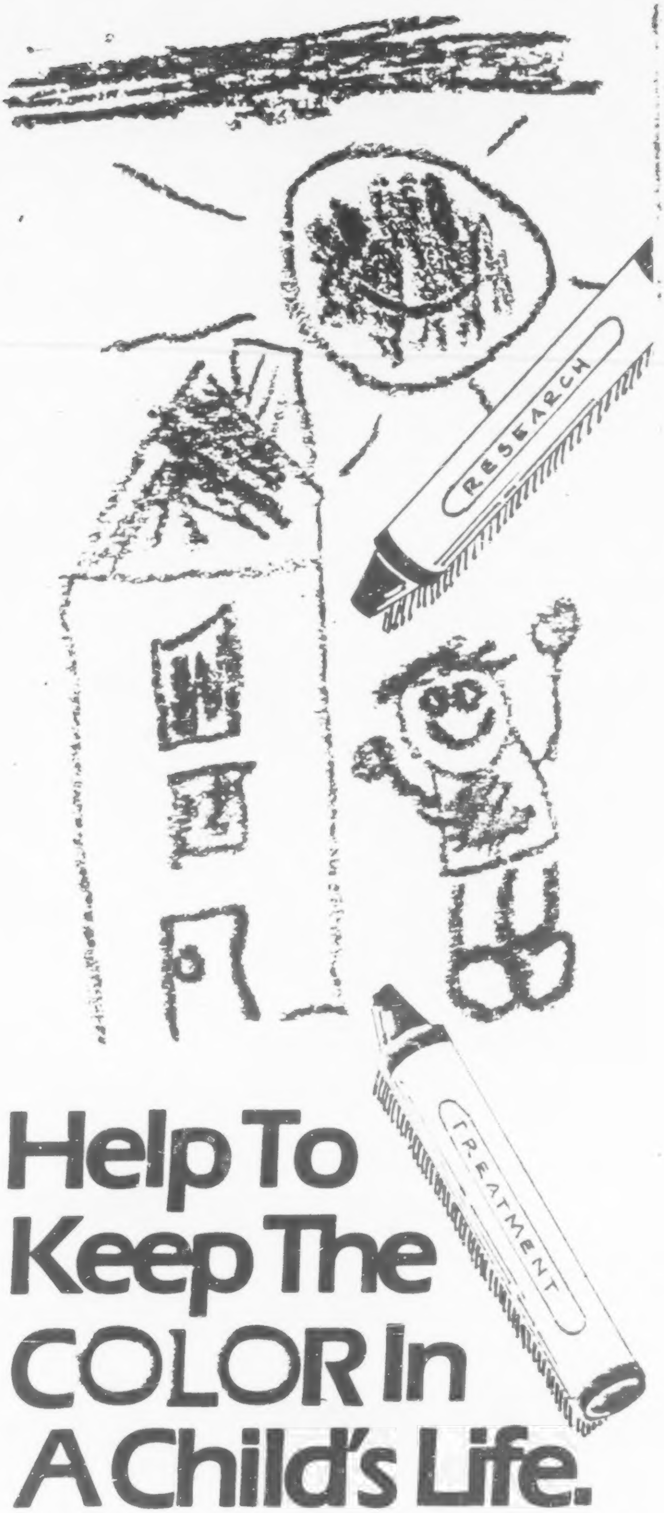
However, in fairness, I do know that the National Institutes of Health is trying to assist in the development of one or more neurogenetic research centers around the country. Whether Batten's disease would play a prominent role in research in these centers is still unknown.

We feel that this gross discrepancy must be remedied and urge the committee to adopt the language as outlined above and further request that you add to this the recommendation that research on Batten's disease be funded up to $1,000,000 a year.

If funding is provided, the chances of the development of a specific treatment program in the near foreseeable future appear to be very good.

Thank you for letting me testify.

[The statement of Dr. Rider follows:]


RESEARCH
TREATMENT
Help To Keep The COLOR In A Child's Life.
THE CHILDREN'S BRAIN DISEASES FOUNDATION FOR RESEARCH

BATTEN'S DISEASE

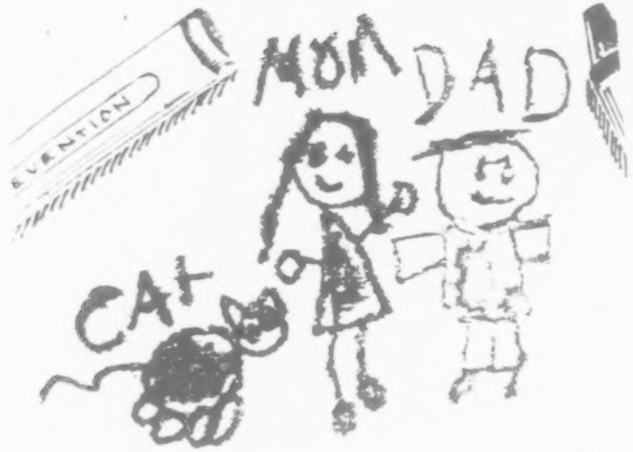
A normal three-year-old has learned to walk and talk. Today, he is happy, active, curious, and irresistible. Suddenly and without warning he becomes sick with a variety of symptoms that are difficult to explain, such as an alarming onset of seizures or convulsions. His family watches as he declines. Within two years he is bedridden and can no longer speak or feed himself. He is now a complete invalid and requires constant care. The joy is gone and, despite all efforts, he soon dies ....

HOW CAN I HELP THIS CHILD?

BATTEN'S DISEASE is a devastating neurological, degenerative disease. It affects persons of all ages, but especially infants, toddlers, and school age children. It begins unexpectedly and leads to early death. It is an inherited disorder affecting the brain and vision primarily and leading to a progressive loss of brain function. Acting through the central nervous system, this disease manifests destruction on all other body functions as well, leaving the child helpless.

CAUSE

While the exact cause of Batten's disease is still unknown, one theory holds that the disease reflects a disorder of the normal degradation of membranes within neurons, leading to an abnormal disposal and accumulation of insoluble lipid-protein complexes. Another theory claims that the disease may be characterized by a disorder in lipid metabolism in the cells, lipids, or fats, and their associated proteins are not processed correctly. Research suggests that there is an abnormal production of lipid perox-



ides and an enzyme deficiency, probably among specific enzymes that digest membrane proteins.

This combination of problems leads to the accumulation of a yellow fluorescent pigment, ceroid lipofuscin, in the brain cells. At this time, the pigment is considered to be the end result of a combination of metabolic derangements and marks the progressive deterioration in brain function. In fact, another name for Batten's disease is neuronal ceroid lipofuscinosis (NCL).

Interestingly, the ceroid pigment is similar biochemically to materials accumulated more slowly during the normal aging process. In Batten's disease, however, the accumulation is quite rapid and destructive. The specific reasons for the loss in brain function are not known. Thus, while there are some promising leads, we still have very little understanding of the specific cause or biochemical mechanism involved in Batten's disease.

SYMPTOMS

Early symptoms of Batten's disease are confusing. Often, they begin with overt changes in personality and behavior and a decline in learning ability. Clumsiness, stumbling, and failing vision soon follow. Most patients have seizures. The child or adult deteriorates progressively. Motor coordination is lost, blindness develops, mental changes become severe, and seizures become more frequent. These changes are particularly devastating in young children who have just begun to experience life; their decline is often quite precipitous and most die within a few years.

Four types of Batten's disease have been identified, based on age of onset and severity of symptoms. These types are infantile, late infantile, juvenile and adult. The order of specific symptoms varies with each type, as may the cause of disease. The infantile type has an onset at approximately age two with seizures and rapid deterioration and death by age 10. Late infantile disease strikes toddlers at three to four years of age with death by age 12. Juveniles may live with blindness, seizures, and mental retardation until their early 20's, while the rarer adult form, beginning in early adulthood, progresses more slowly. The precise history of symptoms helps in establishing a diagnosis of the specific type of Batten's Disease.

DIAGNOSIS

Batten's disease is difficult to diagnose because of the variability in symptoms, insidi-

HeANDMike
TREATMENT

ousness, and age of onset. Children are often thought to have epilepsy or a form of mental retardation. Adults are sometimes labeled schizophrenics. Often, the first diagnostic clue comes with a visit to the ophthalmologist, who observes pathological changes in the retina. Additional tests of neurological and retinal function may help confirm the diagnosis.

Skin biopsies, when examined under an electron microscope, have proven to be especially useful in establishing this diagnosis. In these biopsies, fluorescent and electron microscopy are used to identify the ceroid pigments characteristic of Batten's disease. Biopsies of the lymph nodes, rectal mucosa, liver, and bone marrow may also point to morphological evidence of disease.

Biochemical studies of peripheral tissues, blood components, and urine also may show abnormalities. Researchers are working to improve a blood test to identify children with the disease, as well as carriers. In addition, a urine test has been developed that is helpful for identification. Although researchers are beginning to use electron-microscope analysis of amniotic cells, prenatal diagnosis generally remains unavailable.

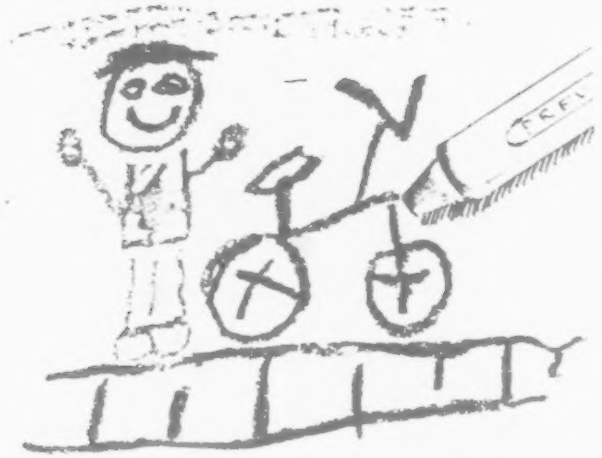
TREATMENT

Today, there is no satisfactory treatment or cure for Batten's disease. The disease progresses until the child or young adult is bedridden and unable to care for himself. Custodial care then becomes necessary. To a large extent, effective treatment will depend on determining the cause and principal mechanisms of action of Batten's disease. Researchers are presently evaluating the effectiveness of enzyme-replacement therapy to overcome an apparent enzyme deficiency. Other studies are assessing the role of antioxidants in the juvenile form and other drugs in enhancing the activity of the enzymes remaining in the tissues of affected patients.

Animal models are important in all these studies. Since the discovery of a disease similar to Batten's disease in dogs and New Zealand sheep, animal models have been invaluable for investigating the disease process; they will be important as well in evaluating possible treatments as they are developed. However, much more research is needed before we can offer real hope.

IMPACT

What is the impact of Batten's disease? Today, Bat-



ten's disease is the most common neurogenerative storage disease of infancy and childhood. The total frequency of all four types may be as high as one in 12, 500 births, similar to other common genetic disorders. An inherited disorder, Batten's disease is carried as an autosomal recessive gene; this means that if both parents carry the gene, each child has a 25-percent chance of being affected. Additionally, each child has a 50-percent chance of inheriting the recessive gene from either or both of his parents and, thus, becoming a carrier, perpetuating the potential for occurrence in subsequent generations.

The emotional and economic impact on the afflicted individuals and their families is overwhelming. Society also bears the burden of the economic costs of this disease. Estimates for the supervision and care for one child for one year range from $50,000 to $100,000. Total costs for skilled nursing care over the child's lifetime can reach $1 million!

PREVENTION

The ultimate goal, then, is to prevent the ravages of this disease. Only through prevention can we avoid the tragedy for those children and families who may have otherwise been struck by this disease. Through prevention we can also reduce the overwhelming economic burden. Accurate detection of carriers and appropriate genetic counseling are imperative if the occurrence of Batten's disease is to be prevented. Through such an effort, we can help reduce the incidence and impact of this disease worldwide.

RESEARCH

The promise lies in research. The challenge is ahead. Although Batten's disease was first described in 1826—more than 150 years ago—the major questions remain unsolved. Batten's disease remains

- Devastating
- Unexpected
- Progressive
- Incurable
- Costly
- Difficult to diagnose
- Of unknown cause
- Unpreventable
- Degenerative
- Fatal at an early age

Research is the hope for tomorrow. Scientists around the world are working today to uncover the cause of Batten's

Me in the Hospital

disease, to delineate the biochemical mechanisms underlying its pathology, to devise accurate methods of detection and diagnosis, to seek clues to effective treatment, and, above all, to develop tools for prevention through genetic counseling. These research efforts draw on many disciplines and utilize the latest biomedical technologies. Animal models will continue to be important as well.

Growing research interest in Batten's disease has resulted in the development of a specific research center—at Indiana University—for the study of this disease. This university center will help to focus and coordinate basic and clinical research in this area. Another research center is being established at the Institute for Basic Research in Developmental Disabilities, 1050 Forest Hill Road, Staten Island, New York. Other research centers are being planned.

The Children's Brain Diseases Foundation for Research strongly supports these efforts against Batten's disease. Established in 1968, the Foundation promotes public understanding of this and other childhood brain diseases and provides research monies to outstanding investigators. Support is needed now to:

- Maintain the momentum of research on Batten's disease
- Pursue scientific opportunities
- Accept the challenge of early diagnosis, effective treatment, and prevention

WON'T YOU HELP?

To support the fight against Batten's disease and/or to obtain more information on this and other childhood brain diseases, please contact:

THE CHILDREN'S BRAIN
DISEASES FOUNDATION
FOR RESEARCH
Parnassus Heights Medical Bldg
Suite 900
350 Parnassus Avenue
San Francisco, California 94117
(415) 566-5402

Children's Brain Diseases

PARNASSUS HEIGHTS MEDICAL BUILDING, Suite 900 • 350 Parnassus Avenue, San Francisco, CA 94117 • 566-5404

Statement

Before

The House Appropriations Subcommittee on Labor, Health and Human Services Education and Related Agencies

By: J. Alfred Rider, M. D., Ph. D., President
Children's Brain Diseases Foundation
350 Parnassus Avenue, Suite 900
San Francisco, CA 94117

Subject: Batten's disease

April 28, 1986

2:00 p.m.

FOUNDATION BOARD OF TRUSTEES:
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Summary of Recommendations

Batten's disease is a neurological disorder which may have an incidence as high as 1 in 12,500 births, similar to other genetic disorders. It is probably the most common type of neurogenetic storage disease in children. It usually manifests itself in previously normal children at the approximate age of 4 to 8 and is characterized by a slow progression of clumsiness, stumbling and failure of vision, seizures, changes in personality and dropping of scholastic grades. The disease eventually leaves them totally disabled and unable to care for themselves and usually ends in death in the late teens or twenties and rarely, into the thirties. The cost of taking care of these children through their lifetime may run well over one million dollars. The changes which occur in the brain in these children are quite similar to many of the changes in the aging person. Thus, effective treatment for Batten's disease may also allow us to alter the aging process of senility in all humans.

The basic cause of the disease is probably due to a defect in the peroxidase enzyme system in the brain. Research must be directed toward obtaining further evidence of this and initiate treatment with agents designed to block the accumulation of peroxidase or enhance its degradation.

We have always supported the budget presented by the National Institute of Neurological and Communicative Disorders and Stroke. We were very pleased that the Committee recommended an appropriation of $428,517,000 for fiscal year 1986 which represents an increase of $32,858,000 over fiscal year 1985.

However, in spite of wording in the 1986 House Appropriation Bill namely: "The Committee reiterates its concern about research on Batten's disease, and requests that the Institute actively solicit applications of quality for research on Batten's disease" very little money has been spent by the National Institute of Neurological and Communicative Disorders and Stroke. We are aware of only one modest grant being funded for fiscal year 1986-1987.

We feel that this gross discrepancy must be remedied and urge the Committee to use the following language in its Appropriation Bill:

> "The Committee is concerned upon learning that in spite of last year's recommendation requesting research on Batten's disease that little research was funded in 1986. Therefore, it requests that the National Institute of Neurological and Communiicative Disorders and Stroke actively solicit applications for grants of quality for Batten's disease and to fund up to $1,000,000 for research on Batten's Disease."

Statement

I am Doctor J. Alfred Rider, President of the Board of Trustees of the Children's Brain Diseases Foundation. It is a pleasure to testify before the House Appropriations Sub-Committee on Labor, Health and Human Services, Education and Related Agencies and support the budget requests of the National Institute of Neurological and Communicative Disorders and Stroke.

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Unfortunately, our abilities to raise money from private sources are limited, and the major monies must come from the NIH. There are over thirty five principal investigators from major universities, medical centers and institutes throughout the world interested in various phases of research pertaining to Batten's disease. (See addendum.) These researchers are in dire need of monies to continue their work.

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If funding is provided, the chances of the development of a specific treatment program in the near forseeable future appear to be very good.

Addendum

Scientists Actively Working in Research on Batten's disease

1. Doctor Donald Armstrong
   Formerly at the University of Florida, Department of Opthalmology
   Relationships of Peroxidase to Batten's disease
   Canine Retinal Degeneration: An Approach to Therapy
   Peroxidase Deficiency & Peroxidase Regulating Enzyme
   Peroxidase Activity in Human and Canine Ceroid-lipofuscinosis, with Special Emphasis on the Eye

2. Doctor Robert J. Baumann
   Department of Neurology
   University of Kentucky & Section on Epidemiology OBE,
   Office of the Director, NINCDS, Bethesda, Maryland
   Leukocyte Ultrastructure

3. Doctor Milton Brightman
   Lab. of Neuropathology & Neuroanatomical Sciences
   NINCS & National Institutes of Public Health/Department of Health and Human Services
   Transport of Horseradish Peroxidase Across Blood Brain Barrier

4. Doctor Glyn Dawson
   Associate Professor,Depts.of Pediatrics and Biochemistry
   The University of Chicago
   Pre-Natal Diagnosis and Enzyme Replacement Therapy
   Approaches to the Detection of Neuronal Ceroid Lipofuscinosis in Cultured Skin Fibroblasts

5. Doctor T. L. Dormandy
   Whittington Hospital, London
   Free Radicals and Lipopigments

6. Doctor Edward Dratz
   Associate Professor of Chemistry & Biochemistry
   University of California, Santa Cruz
   Measurement of Fluorescent Lipopigment, Peroxidized Fatty Acids, Vitamin E, Effects of Antioxidants on Lipopigment Formation

7. Doctor Graig E. Eldred

Institute of Opthamology, University of Missouri-Columbia, Missouri
Lipofuscinogenesis in the Retinal Pigment Epithelium

8. Doctor Paul Glees
University of Cambridge, Anatomy School, Cambridge
Electron Microscopic Studies on Neural Lipofuscin: Accumulation and Removal
The Effects of Centrophenoxine in the Central Nervous System

9. Doctor H. H. Goebel
Division of Neuropathology, University of Gottingen
The Ultrastructural Spectrum and Diversity of Lipopigments in the Neuronal Ceroid-Lipofuscinosis

10. Doctor John M. C. Gutteridge
Division of Antibiotics, National Institute for Biological Standards and Control, Holly Hill, Hampstead, London
Flurorescent Products of Phospholipid Peroxidation: Formation and Inhibition in Model Systems

11. Doctor Egill Hansen
Department of Opthalmology, Rikshopitalet, The National Hospital, University of Oslo, Norway
The Significance of Psychophysical and Electrophysical Methods in the Diagnosis of Juvenile Neuronal Ceroid-Lipofuscinosis

12. Doctor Ann Harden
Department of Clinical Neurophysiology, The Hospital for Sick Children, London
Neurophysiological Studies in Children with so-called Neuronal Ceroid-Lipofuscinosis

13. Doctor Denham Harman
The University of Nebraska Medical Center
Brain Lipid Composition

14. Doctor K. U. Ingold
Associate Director, National Research Council of Canada
Division of Chemistry
Resistance to Oxidation and the Natural Antioxidant Levels in Membranes from Human Cells

15. Doctor Gunde Egeskov Jensen
The Laboratory of Biochemistry and Toxicology, The Institute of Biology and Chemistry, University of Roskilde, Denmark
Glutathione Peroxidase Activity in Leucocytes, Erythrocytes and Serum from Juvenile Form of Neuronal Ceroid-Lipofuscinosis

16. Doctor R. D. Jolly
Department of Veterinary Pathology and Public Health, Massey University, Palmerston North, New Zealand
Ceroid-Lipofuscinosis: The Ovine Model
Studies on Mannosidosis and Ceroid-Lipofuscinosis in Cattle, Sheep and Dogs

17. Doctor Edwin Kolodny
Associate Director, Eunice Kennedy Shriver Center For Mental Retardation, Inc., Waltham, Massachusetts
Pathogensis of the Neuronal Ceroid-Lipofuscinosis

18. Doctor Nils Koppang
Veterinaerinstuttet, Oslo, Norway
Histochemical Evidence of Lipid Peroxidation in Canine Ceroid-Lipofuscinosis

19. Doctor Martin M. Maltempo
Assistant Professor of Physics, University of Colorado Medical Center
Monitoring of Peroxidase and Free Radicals in Canine Retinal Tissue Subject to a Degenerative Disease in which there is an Accumulation of Pathologic Lipopigments of the Ceroid Type: A Model for Batten's disease

20. Doctor Jaime Miguel
NASA, Ames Research Center, Moffett Field, CA
Analysis of Pigment Lipofuscin

21. Doctor Erling Gronvold Olsen
University Eye Department, Rikshospitalet, University of Oslo, Norway
Fluorescein Angiography in Ceroid-Lipofuscinosis

22. Doctor Vimal Patel
Assistant Professor of Pathology
Indiana University School of Medicine

Antioxidant Treatment of Batten's disease

23. Doctor Alan K. Percy
Associate Dean, Office of Research, Charles R. Drew Postgraduate Medical School, Los Angeles
Salutory Effect of Selenium, Erythrocyte Glutathione Peroxidase

24. Doctor Michel Philippart
Neuropsychiatric Institute, University of California, Los Angeles
Treatment of Batten's disease with Antioxidants

25. Doctor Mark Poznansky
Associate Professor of Pathology, University of Alberta
Enzyme Replacement and Enzyme Engineering

26. Doctor Raju Pullarkat
New York State Institute for Basic Research in Mental Retardation, Staten Island, New York
Lipopigments in Aging and in Ceroid-lipofuscinosis
Docosahexaenoic Acid Levels in Brains of Various Forms of Ceroid-lipofuscinosis

27. Doctor Julius Schultz
Director, Pananicolaou Cancer Research Institute, Miami, Florida
Discovery and Characteristics of Leukocyte Peroxidase and the Purification and Administration to Animals

28. Doctor Gunther Schwendemann
Division of Neuropathology, University Hospital, Eppendorf, Hamburg
Diagnosis of Juvenile Ceroid-Lipofuscinosis by Electron Microscopy of Lymphocytes and of Rectal, Skin and Sural Nerve Biopsy Tissue

29. Doctor A. N. Siakotos
Professor of Pathology, Indiana University Medical Center
Development of a Reliable Blood Test for Batten's Disease
Recent Developments in the Isolation and Properties of Autofluorescent Lipopigments

30. Doctor P. E. Spoerri

Department of Histology and Neuroanatomy, University of Gottingen, Sweden
Ultrastructural Age Changes in Neurons and Myocardium in Culture. The Effects of Centrophenoxine on Age Pigment

31. Doctor Satish Srivastava
Department of Human Biological Chemistry & Genetics
The Unviersity of Texas Medical Branch
Purification and Properties of Leukocyte Peroxidase
Biochemical Studies in Neuronal Ceroid-Lipofuscinosis

32. Doctor Al Tappel
Division of Food Science & Technology, University of California, Davis
Properties and Functions of Glutathione Peroxidase and Pentane Analysis of Lipid Peroxidation Damage to Quantitate Effects in Nutrition

33. Doctor T. Westermarck
Rinnekoti Institution for the Mentally Retarded, Espoo, Institute of Radiation Protection, Helskinki, Finland
Sodium Selenite Absorption and Losses in Spielmeyer-Sjogren Type of Neuronal Ceroid-Lipofuscinosis (Batten's disease) Using Total Body Counting for 75 SE Detection
Studies on the Effects of Selenium Administration to Neuronal Ceroid-Lipofuscinosis Patients with Special Reference to Reduced Gluthathione

34. Doctor John R. Wherrett
Professor of Neurology Program, University of Toronto
Isolation of Fluorescent Material in the Juvenile Form of Batten`s disease

35. Doctor Leon Wolfe
Hopital Neurologique de Montreal, Montreal Neurological Hospital, Canada
Characterization of the Accumulated Retinal Compounds in Batten's disease
An Analysis of Urine Sediment in Subjects with Batten's disease

MONDAY, APRIL 28, 1986.

SLEEP DISORDERS

WITNESSES

MERRILL M. MITLER, EXECUTIVE SECRETARY/TREASURER, ASSOCIATION OF SLEEP DISORDERS CENTERS

TAMARA S. JOHNSTONE, FEDERAL LIAISON

Mr. NATCHER. Our next witness is Dr. Merrill M. Mitler. We are glad to have you before the committee.

Mr. MITLER. I am Dr. Merrill M. Mitler, a psychologist trained in the physiology of sleep. I have worked for more than 20 years in this field.

I represent the Association of Sleep Disorders Centers, an organization of some 2,000 specialists working at medical schools and major hospitals throughout the country. I also represent all humans.

All of us know the miseries and errors we make when we try to work during the time we should be sleeping.

President Reagan has publicly recognized these problems. The White House announced that his trip to Tokyo would begin several days prior to the time he must negotiate on economic matters. The extra days permit the President to adjust to the time differences between Tokyo and Washington.

The errors of trying to function when sleepy can be catastrophic. In San Diego, last year, a school bus driver fell asleep at the wheel and caused numerous injuries and several deaths to his charges.

Our field knows that sleep tendency influences, not only performance and judgment, but also resistance to disease.

In a report dated March 6, 1986, requested by the Senate Appropriations Committee, NIH concludes that "sleep disorders research encompasses a broad area of research supported by NIH, ADAMHA, and HRSA.

I want to show you why NIH is so interested in sleep. Disease-related death in New York City. Morning and afternoon peak in human mortality. This rise begins shortly after midnight and continues throughout the usual sleeping hours.

This week in the New England Journal of Medicine, we show that there is a link between such deaths and the time when heart attacks occur. So the phenomenon represented by this curve probably extends to disease-related morbid events such as heart attack.

This phenomenon is not new. Here you see data dating to the late 1800s, morning peak and afternoon peak in human mortality. Coincidence of peaks in human mortality with peaks in tendency for sleep.

So, while we have known for some time that there are certain times of day when morbidity and mortality peak, we now see that there are connections with sleep and with certain types of disease.

Therefore, we have hope of identifying people at risk for morbid or mortal events and designing methods of prevention.

Our field has worked for some 25 years to identify areas within the brain that control sleep. These cell complexes lie here in the medial areas of the brain ranging from the front, forebrain, to the rear, medulla.

However, we urgently need basic research directed at the exact sequence of events that lead to medical catastrophes during sleep.

We applaud your committee's past support of biomedical research. We commend the NIH for its recognition of the many interactions between diseases and sleep. And we request that your committee take steps to insure that proper HHS support is available to integrate the rich knowledge of our field with the ongoing research programs at ADAMHA, NIH and HRSA.

Thank you for this opportunity to address the committee. I would be pleased to answer any questions.

Mr. NATCHER. Thank you very much, Dr. Mitler. We appreciate your appearance. You, too, have made an excellent statement.

[The statement of Mr. Mitler follows:]

ASSOCIATION OF SLEEP DISORDERS CENTERS

Testimony of

Merrill M. Mitler, Ph. D.

of the

Association of Sleep Disorders Centers/Clinical Sleep Society

before the

House Appropriations Committee
Subcommittee on Labor, Health and Human Services, and Education
and Related Agencies

concerning

Funding for Sleep Disorders Research

April 28, 1986

Mr. Chairman, distinguished Members of Congress, ladies and gentlemen, I am Dr. Merrill M. Mitler, a psychologist trained in the physiology of sleep. I have worked in this area for the last 20 years.

I represent The Association of Sleep Disorders Centers/Clinical Sleep Society, which is made up of over 2000 clinical specialists working at medical schools and hospitals throughout the country.

I also feel that I represent all humans when they sleep. I say this because in all of the Governmental agencies, committees and institutes, there is no one charged with the responsibility for health and welfare during the third of our lives that we call sleep.

Everyone sleeps. We need sleep to survive. We must have good sleep to be alert throughout the day. If our sleep is abnormal, we may die. Or, at the very least, our waking functions will be impaired. Considering all who have persistent insomnia, all who have difficulty staying awake during the day and all who have sleep disruption due to chronic illness, over 100 million Americans do not have good sleep. Such people stop breathing when they fall asleep, they have insomnia and they involuntarily fall asleep while driving or working.

Sleep is not a quiet "time out" for the body. Sleep is actively induced and exquisitely orchestrated. But, when the brain goes to sleep, many diseases, particularly those of the respiratory and circulatory systems, are adversely affected.

Sleep pathology affects all ages. In infancy there is Sudden Infant Death

Syndrome. In adolescence there is failure in school and motor vehicle accidents from chronic sleep loss, alone or in combination with drugs and alcohol. In adulthood there is risk of sudden death during the night. In the elderly death rates rise markedly during the hours of sleep. And, there is deterioration of sleep in response to disorders such as arthritis, heart disease and chronic pulmonary diseases. Over half of all Americans over 65 are thought to have specific sleep disorders.

We need governmental help to establish policies in areas where public safety is affected and to support research on the fundamental role of sleep in health and disease.

Here are examples of specific research questions.

QUESTION 1: WHICH PATIENTS ARE AT RISK FOR DEATH OR DISABILITY FROM HEART ATTACK, STROKE AND SEIZURES WHEN THEY SLEEP?

Major medical problems leading to death or disability can arise during the night. These medical catastrophes seem to occur most frequently between midnight and 6 AM. Heart problems during sleep and breathing problems during sleep are usually involved.

People with the clinical signs of such cardio-pulmonary problems during sleep are demanding treatment and physicians are treating. For example, my colleagues in this country see about 500 new patients each week with the condition of sleep apnea in which breath stoppages lasting for a minute or more can occur hundreds of times each night. Medical costs of diagnosis and the initial surgical and medical treatments for these particular sleep disorders average about $5000 per patient -- or $130 million dollars annually.

There is no federally funded research on the long-term efficacy of any of the surgical and medical treatments now used.

QUESTION 2: WHICH SLEEPING PILLS ARE SAFE FOR PATIENTS WITH CHRONIC INSOMNIA?

Over 200 million dollars is spent on sleeping pills alone each year. Most prescriptions are given to chronic users. But the long-term safety of these drugs is unknown.

The Institute of Medicine has recently recommended that more research on sleeping pill safety should be done.

QUESTION 3: WHICH PATIENTS SHOULD NOT DRIVE MOTOR VEHICLES, PILOT AIRPLANES OR OPERATE DANGEROUS EQUIPMENT BECAUSE THEY CANNOT STAY AWAKE?

Public policy concerning somnolence on the roads, in the airways, and in the work place is virtually nonexistent.

Generally speaking, the obstacle for sleep research has been "lack of designated responsibility" within HHS. Our research questions do not fit neatly into the missions of any one HHS's institution. Research in sleep disorders cut across the fields of neurology, pulmonary medicine, psychology, gerontology and psychiatry. The few grants for sleep research have come from The National Institute of Neurological and Communicative Disorders and Stroke and The National Heart, Lung and Blood Institute, both in NIH as well as the National Institute of Mental Health in ADAMHA. This has been an financially unstable situation for sleep research.

In 1986, the amount of Federal research money devoted to sleep research amounted to less than one half of one percent of the amount the public spent on health care for sleep pathologies. This is a very low ratio compared with other disease categories. In this fiscal year, the effect of the Gramm-Rudman Balanced Budget Act of 1985 is slated to reduce funding to NIH and ADHAMA by less than five percent. While this amount may sound like an acceptably small reduction, it has caused a virtual cessation of crucial sleep research. When funding for extramural research programs are facing cutbacks, the tendency is to withdraw from interdisciplinary efforts. Funding for biomedical research in our area is now so uncertain that some of my colleagues are leaving the field entirely. We applaud your committee's efforts to protect funding for biomedical research. But, uncertainties and the cuts of fiscal 1986 have already reduced funding for sleep research by over 90%. People have been laid-off and sleep research programs have been shut-down. There is now a climate of uncertainty among my colleagues, yet they are increasingly beleaguered with the difficult clinical problems I have outlined for you.

We request that Federal policy recognize the health and safety issues related to sleep pathology and that research funding reflect the financial and social impact that sleep pathology has on our society. Thank you.

MONDAY, APRIL 28, 1986.

CHRONIC EPSTEIN-BARR VIRUS

WITNESS

THEODORE W. VAN ZELST, GLENVIEW, ILLINOIS

Mr. NATCHER. Our next witness is Mr. Theodore W. Van Zelst. Come around, Mr. Van Zelst. We are delighted to have you before the committee.

Mr. VAN ZELST. Mr. Chairman, ladies and gentlemen, my name is Theodore Van Zelst. I am here as an individual and representing Minann, a foundation active on matters related to a relatively unknown disease, Chronic Epstein-Barr Virus Infection, CEBV.

Two years after my original testimony to this committee, many patients have been identified and we know a little more about the disease which has sometimes been called "chronic mononucleosis."

Research is underway with private and governmental support, but lack of funding or reductions have forced some researchers to discontinue their studies.

What are typical CEBV symptoms? Recent survey data indicate that in patients ill two years or more, 80 percent of them reported extreme debilitating fatigue, muscle aches, sore throat, headaches, dizziness and depression.

Patients with CEBV have been surprised to learn a name for their illness from newspapers, magazines, radio and TV. As more media attention is given to this disease, more people who have the symptoms of CEBV seek information and diagnosis.

Many wrote to Minann and support groups to tell about their symptoms, the difficulty of finding a diagnosis, the lack of awareness of the existence of the disease by their doctors and family, and their desperate search for information.

Since CEBV articles appeared in the Annals of Internal Medicine in January 1985 and received media coverage, Minann has processed over 7,000 requests for a CEBV Information Bulletin.

About 1200 people with CEBV concerns responded to a recent medical survey. Of those responding, 702 had received at least one positive titers blood test, a diagnostic indicator of the chronic form of the Epstein-Barr virus.

A national organization and over 100 self-help support groups assist patients and researchers throughout the country.

The story of CEBV and its many patients is best told by these typical excerpts from 1300 personal letters Minann has received.

> Being a CEBV victim, I have been through indescribable hell, doctor and hospital visits, incorrect diagnoses and loss of several well-paying jobs.

Another patient.

> I have been ill with CEBV. I am very sick right now, unable to work, I am feeling so helpless and very depressed.
>
> I am a 20-year-old female and sometimes I feel so helpless and sick I want to kill myself. People say, "You will get over it soon," but I really don't think this virus will ever leave my body. I have seen 12 doctors and none of them know a thing about this disease.

In preparing this statement, I asked some of the research physicians to comment on their research and future objectives:

Dr. Irena Brus, Mt. Sinai School of Medicine, New York:

> The cause of the disease, its incidence and its natural history are not fully understood. There is yet no known treatment of chronic EBV disease. Better diagnostic tools are needed.

Dr. James Jones, National Jewish Medical Center, Denver, suggests the direction research should take:

> Evaluate and define the CEBV syndrome. We must know appropriate diagnostic criteria for the syndrome and the patient distribution and numbers.

Dr. Werner Henle, Childrens Hospital of Philadelphia:

> We still do not have solid data on the incidence as observed in the wake of primary EBV infection: Infectious mononucleosis. A study of patients convalescent from infectious mononucleosis is urgently needed to determine what percentage develops chronic, continuous or intermittent illness.

New concerns about CEBV. There may be small epidemics occurring. Under study are a reported 140 cases in the Incline Village, California area in December 1985; a similar outbreak in a rural community, Yerington, Nevada; at a university in Washington; and another of workers in an office building in New England. Doctors have recently become aware of a large number of patients in San Francisco who may be afflicted.

I believe the events outlines partially answer the question, "How many people have this disease?" There are many more than have been anticipated.

The question of the incidence of CEBV will not be fully answered as long as patients themselves must seek ways of finding out this information.

We ask this committee to recommend, one, that NIH's National Institute of Allergy and Infectious Diseases conduct or sponsor more research on the chronic form of the Epstein-Barr Virus Infection in search of better techniques for diagnosis, treatment and hopefully, an eventual cure.

Two, that a protocol be established through the National Institutes of Health or Centers for Disease Control for reporting the incidence of the chronic form of the Epstein-Barr Virus by physicians. This reporting should be set up as a clearinghouse of medical information to assist physicians, researchers and patients.

Thank you very much, Mr. Chairman.

Mr. NATCHER. Thank you very much, you have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Mr. Van Zelst follows:]

STATEMENT BY THEODORE W. VAN ZELST, MINANN, INC.
TO THE HOUSE LABOR, HEALTH AND HUMAN SERVICES
EDUCATION AND RELATED AGENCIES
APPROPRIATIONS SUBCOMMITTEE

RESEARCH AND REPORTING PROTOCOL NEEDS FOR CHRONIC ACTIVE EPSTEIN-BARR VIRUS INFECTION (CEBV)

Washington, D.C.   2:10 pm, April 28, 1986

Theodore W. Van Zelst
c/o Minann, Inc.
Box 582
Glenview, IL 60025

(c)

STATEMENT BY THEODORE W. VAN ZELST, MINANN, INC.
TO THE HOUSE APPROPRIATIONS SUBCOMMITTEE, LABOR, HEALTH & HUMAN SERVICES
EDUCATION AND RELATED AGENCIES

Washington, D.C. April 28, 1986

Subject: Research and Reporting Protocol Needs for
Chronic Active Epstein-Barr Virus Infection (CEBV)

Mr. Chairman, my name is Theodore W. Van Zelst. I am here today as an individual and also as president of Minann, Inc., a foundation which for the past three years has been actively involved on matters related to a relatively unknown disease, Chronic Active Epstein-Barr Virus Infection (CEBV).

Until recently the chronic form of the Epstein-Barr virus was almost unknown even to the medical profession. However, with the publication of articles in medical journals during the past 18 months, there has been a greater awareness of this disease. Studies are underway to try to learn more about the incidence of this disease. Minann and CEBV support groups around the country have received thousands of requests for information from people who have been diagnosed with CEBV or who believe they may be afflicted with this disease.

Now, two years after my original testimony, many patients have been identified and we know a little more about the incidence of the disease, which has sometimes been called chronic mononucleosis. The Epstein-Barr virus is a virus that causes infectious mononucleosis in adults and often results in subclinical infection in children. More research is underway with private and governmental support. However, lack of funding or reductions have forced a number of CEBV physician/researchers to discontinue their research on CEBV and related viruses.

Through this testimony, I want to give a brief update on progress that has been made in the past two years, and again stress the need for more research activity on the chronic form of the Epstein-Barr virus. We appeal to this Subcommittee to recommend that the NIH-National Institute of Allergy and Infectious Diseases and the Centers for Disease Control/Herpes Branch use funds to expand research activity on this complex disease.

What are typical CEBV symptoms? Recent survey data indicate that in patients who have been ill 2 years or more, 80% of them reported extreme debilitating fatigue/exhaustion; muscle aches; sore throat; headaches; difficulty in concentrating; dizziness; depression and irritability. Extreme fatigue was reported to be constant and unrelieved by 64% of the patients.

Patients with this little known disease have been surprised to learn about it from newspapers, magazine articles, radio and TV. Chronic Epstein-Barr Virus infection afflicts an unknown number of people. As more media attention is given to this illness, many more people who have symptoms of CEBV seek information and diagnosis. Many of the patients wrote to Minann and support groups to tell about their symptoms; the difficulty of finding a diagnosis; the lack of awareness of the existence of the chronic form of EBV by their doctors, family and friends; and their desperate search for information to try to explain their illness.

The media coverage has done much to give hope and credibility to many patients. They were able to show printed evidence to their doctors, family, friends and employers to demonstrate that their symptoms have been recognized and that it is not 'all in the mind.'

The CEBV articles made patients aware that they were not alone in the struggle with this debilitating illness. Through volunteer work, patients have been able to get in touch with each other to validate the existence of their illness, to discuss with others who understand the pain of this disease, and to share the mechanisms for coping with chronic illness. The recently organized National C.E.B.V. Syndrome Assoc, Box 230108, Portland, Oregon, 97223 has received over 2500 requests in the first three months of 1986 asking for information about CEBV. Over 100 self-help support groups assist patients, families and researchers who are interested in CEBV.

Since CEBV articles appeared in the Annals of Internal Medicine in January, 1985 and received popular media coverage, Minann has processed over 7000 individual requests for a CEBV Information Bulletin. Among these requests were over 1300 personal letters from people detailing how CEBV has devastated their lives.

About 1200 people with CEBV concerns responded to a medical survey conducted by Minann and Doreen Clark of New Jersey who operates a market research firm. The data analysis presents interesting facts about this disease. Of those responding, 702 had received at least one positive titers blood test, a diagnostic indicator of the chronic form of the Epstein-Barr virus. Even though there is no known treatment or cure for CEBV at this time, a positive diagnosis can at least validate the existence of real illness. The survey should be of great value to researchers studying the incidence and characteristics of CEBV. Copies of the preliminary information from the survey have been made available to CEBV researchers. See Addendum A.

The letters received by Minann can be categorized into 3 groups: (1) people who have been diagnosed with CEBV; (2) the large number who have symptoms which they believe are related to CEBV; (3) others reporting about family members or friends seeking information. These letters identify the increasing number of people who have been diagnosed with CEBV, and indicate their concerns and hopes for research leading to treatment and eventual cure.

The story of Chronic Epstein-Barr Virus Infection and its many patients is best told by these excerpts from over 1300 letters Minann has received from those afflicted by the disease. These letters are not unique -- but typical.

...I am desperately seeking some kind of support group or information organization as CEBV has left me totally alienated from my family (they think it is all in my head) and separated from my friends at a time when physical and social contact is absolutely essential to combat depression and loneliness.(California)

...I have just been diagnosed as having CEBV. Immediate concern is how to keep from contaminating others. I am concerned for other members of my family. (California)

...I was diagnosed with CEBV which I'm sure I've had for 25 years. I would like to know if there is a contagion factor, especially for people in the same household. I am a part time school teacher and I certainly don't want to infect the children. (Illinois)

...Being a CEBV victim, during the past 5 years I've been through undescribable hell, medical visits, hospital visits, incorrect medical diagnoses, i.e., possible brain tumor, multiple sclerosis, etc. as well as loss of several well paying jobs. (Colorado)

...I have been ill with CEBV. I am very sick right now, unable to work and have had to pull out of school. I'm feeling so helpless, no control of anything in my life and very depressed. (Illinois)

...I am a 20 year old female and sometimes I feel so helpless and sick I want to kill myself. Lots of people say, 'Oh, you'll get over it soon!' -- but I really don't think this virus will ever leave my body. I've seen 12 doctors and none of them know a thing about this disease. They all tell me that it should only last about 3 or 4 months at the most and that all of my symptoms are just in my head. (Ohio)

...I would love to go to a doctor who is aware of CEBV and could possibly diagnose me. I am so tired of not having an organic cause for my illness. I know it's there. To have someone else verify it would mean so much to me. (California)

...My 17 year old son has had problems with the EB virus. No doctor has been able to help. He has graduated with honors and goes away to college this Fall. He has such potential as a student and has struggled so hard to keep the illness from holding him back. We are concerned that the severity and length of fatigue will jeopardize his future. (California)

Many CEBV patients are accused of having psychiatric afflictions. A letter from a Massachusetts 24 year old tells that part of the story: I was admitted to a private psychiatric hospital where the psychiatrist quickly picked up on the presence of the medical condition and was determined to find the culprit. I was diagnosed as having CEBV. The emotional toll is unbelievable, both on myself and my loved ones. I am devastated.

..After a year of being mis-diagnosed for 'viral problems', I found my way to a physician aware of this illness. I find this virus disabling and distressing. I am a 32 year old flight attendant and spend 5 to 10 hours in an enclosed environment. I feel this problem is widespread in the company. I have not shown any improvement and have currently taken 6 weeks rest from work. It is my doctor's feeling that I may eventually have to quit my career because of the long and irregular hours. I am deeply upset from the uncertain future that having this virus places on me. (New Jersey)

...I am a physician who has been ill with chronic Epstein-Barr virus syndrome for the past nine years. I have addressed myself to understanding my illness and attempting to recover health for myself and others with similar problems. Recently I began leading a support group for area patients with CEBV. (Maryland)

A registered nurse specializing in cancer patient care: Being unable to work for the past two years due to CEBV, I have used my expertise to collect data, assess the needs of and create a support group network for the patients afflicted with CEBV, and to disseminate information to the medical community with the goal of increasing their awareness of the existence of Chronic Epstein-Barr Virus . (New York)

There is research underway on this disease. In preparing this testimony, I asked some of the research physicians for comments regarding their ongoing research and some of their objectives for future studies. The following comments are excerpted from their letters:

Irena Brus, M.D., Dept. of Clinical Medicine, Mt. Sinai School of Medicine, New York, New York states: Symptomatic chronic EBV disease very likely exists as a distinct entity...the cause of the disease, its incidence and its natural history are not fully understood...There is yet no known treatment of chronic EBV disease. Better diagnostic tools are needed. For better understanding of the disease more extensive monitoring of persons with chronic unexplained illness following acute infectious mononucleosis should be done.

There should not only be an evaluation of serological findings, but also quantity of infectious virus in oral secretions and EBV genome content in peripheral blood cells and some tissues. Those prospective studies should be done during relapse and remission of this chronic illness. The results should be compared with those obtained from serial prolonged observation of healthy people with prior primary EBV infection presenting as acute IM, non-IM clinical syndrome or unaccompanied by any acute symptomatology.

I am currently starting treatment of a group of patients with chronic EBV disease using IV gammaglobulin. I suspect, that immunoglobulin supplementation by this drug rich in neutralizing antibodies to EBV could exert benefits.

Clinical trials with an EBV vaccine are expected to start within the next few years. A prototype vaccine developed by M.A. Epstein & colleagues at the University of Bristol (UK) has been shown to be effective in EBV infection in animals and both chemically synthesized polypeptides and genetically engineered antigens are also being investigated. Dr. Kiefe of the University of Chicago has reportedly cloned a gene for an EBV antigen in bacteria (3/86 issue of MRC News).

The importance of these studies cannot be overestimated since it may mean future eradication of EBV, the world wide present and far from being innocent infectious agent.

There is increasing evidence for a link between chronic EBV infection and the production of certain autoantibodies characteristic of collagen vascular disease. ...In collaboration with Dr. Westley Reeves from Rockefeller University, we will shortly begin a study on the relationship of chronic EBV infection to Sjogren syndrome.

There is progress in studying of this new syndrome (CEBV). However, with few exceptions clinical and laboratory research is done by physicians without financial support and this is an important limiting factor. Proper clinical evaluation of patients is hampered since patients often do not have funds or insurance for lab tests or doctors visits. Many of them are disabled. Disability procedures are lengthy and tiresome and often result in denials often due to rigidity of evaluating personnel and lack of 'official' acceptance of chronic EBV disease.

——Statement regarding CEBV by Theodore W. Van Zelst 4/28/86 (5)

Richard E. Du Bois, M.D., Atlanta Medical Associates, Atlanta, Georgia:

I continue to follow a great many cases of chronic EBV infection...I do feel that research is needed regarding the role of ADCC antibody and the synergistic role with Cytomegalovirus in the chronic EBV state. I think that the (2':5') Oligo A Synthetase activity assay would also be extremely helpful in differentiating patients with chronic active disease from those simply having positive serology. This test is expensive and generally not available, but does seem to be positive in the chronic active state.

...I also think that research into such drugs as Isoprinosine (an immune enhancer) would be helpful to delineate whether long-term usage would give symptomatic relief of these symptoms. ...It is also clear that the association of EBV with depression needs to be investigated in depth...also further investigation regarding association of EBV with autoimmunity.

The number of patients with EBV is increasing steadily and the lay press has been more attentive to it than the scientific press.

James F. Jones, M.D., National Jewish Center for Immunology & Respiratory Medicine, Denver, Colorado suggests the direction research should take:

1) Evaluate and define the CEBV syndrome. We must know appropriate diagnostic criteria for the syndrome and the patient distribution and numbers.

2) Look at the psychological parameters of the illness. Patients complain of not being able to remember, to concentrate and therefore are unable to function on their jobs or in school.

3) Evaluation of sleep problems of patients. Preliminary data suggest that there are electrophysiological differences between these patients and other individuals during sleep.

4) Evaluation of why 80% of these individuals with CEBV have IgE-mediated allergy disease.

5) Basic immunology should be studied. Are there differences among patients with this syndrome and other patients who have been exposed to the virus?

6) Evaluation of the virus. Is the virus in this syndrome different from the virus which apparently causes infectious mononucleosis?

7) Mechanism of reactivation. Are there factors such as stress, environmental factors... that may be of importance?

8) Therapeutic investigation must occur at the same time the above investigative procedures are being performed.

James C. Niederman, M.D., Yale University, Dept. of Epidemiological & Public Health, New Haven, Connecticut reports on CEBV research studies:

The objectives of my ongoing research on chronic EBV infections is to characterize more precisely the syndrome of chronic infectious mononucleosis and to identify specific serologic markers for differentiations of latent asymptomatic EBV infection from chronic active symptomatic infection. We anticipate that the syndrome of chronic mononucleosis will likely include a heterogenous group of disorders. ...If functional protein defects could be unmasked in cases of chronic symptomatic Epstein-Barr infection, it might be possible to correct them through the therapeutic use of specific human immunoglobulin-containing antibody to the deficient protein.

Dr. Niederman continues:...Dr. George Miller and I are studying patients with chronic mononucleosis and individuals with acute uncomplicated infectious mononucleosis, representing primary infection as controls.

Werner Henle, M.D., Prof. of Virology, Children's Hospital of Philadelphia, Philadelphia, Pennsylvania: I shall outline briefly what I consider the most urgent studies that are needed regarding Chronic Epstein-Barr Virus Infection (CEBV):

We still do not have solid data on the incidence as observed in the wake of primary EBV infection; ie: infectious mononucleosis (IM). A prospective study of patients convalescent from IM is urgently needed to determine what % develops chronic continuous or intermittent illness. Such studies must include comparison of EBV-specific antibody profiles of patients who recover rapidly and of patients who develop prolonged disease in order to detect differences that might be of diagnostic significance.

At present we divide patients with so-called chronic EBV infection into four groups, although the dividing lines may not be sharp and the groups may overlap. Group I contains the fortunately rare patients who in the wake of IM develop one life-threatening complication after another involving the central nervous system, liver, lungs, white blood cells, etc. These patients are severely ill for years and show excessively high titers to antibodies to the EB viral capsid antigen, and to the diffuse component of the early antigen complex (up to 1:80,000 or 1:10,000 respectively). There is no question that these cases are due to EBV but undoubtedly in conjunction with cellular immune defects.

Groups II and III involve patients who complain of intermittent or continuous fatigue, malaise, nausea, depression, headache, fever, lympadenopathy, etc. Their symptoms were not necessarily ushered in by IM but often arose many years later or in the absence of a history of IM. Group II shows elevated antibody titers to VCA (1:640-1:2560) and to early antigen of the D or R (restricted) type of at least 1:40 and as high as 1:640. In Group III antibodies to VCA are well within normal range, and antibodies to EA are absent or reach at most titers of 1:40. These serological data suggest that EBV might be the cause of illness in Group II, but probably not in Group III, other causative agents must be considered. The need for this is clearly indicated by the last Group IV which comprises patients with the same complaints as voiced by patients in Groups II, and III but who are still seronegative and thus have not yet been infected with EBV.

It seems essential to delineate the clinical complaints of Groups II, III and IV further in an effort to discover possible differences. Most important, these patients should be examined systematically for other infectious agents that might be the cause of their complaints. These efforts must involve attempts at isolation of the agent(s) and search for various virus-specific antibodies. This will be a major undertaking. Patients also should be carefully evaluated for any signs of cellular immunodeficiencies and for allergies which seem to be a frequent occurence in the so-called chronic EBV infections.

...There is a possibility that studies of the kind suggested above may be initiated by the Department of Medicine of the University of Pennsylvania. The patient material and the various needed disciplines are there, but not the funds.

New concerns about this disease have developed. In addition to individual cases which have been reported previously, there may be small epidemics of CEBV occuring. An outbreak of a reported 140 cases of CEBV in the Incline Village, California area in December 1985 is under study. There was a similar outbreak in a rural community, Yerington, Nevada. There was a recent report of a number of cases at a university in Washington, and another of workers in an office building in the New England area. Anthony L. Komaroff, M.D., Chief of General Medicine, Brigham & Womens's Hospital and Harvard Medical School, is conducting a study on these outbreaks. Data collection has been completed and is now being analyzed. Dr. Komaroff observed that since the California-Nevada outbreaks occured in epidemic form, it is possible that it is different from the CEBV illness that has been seen in endemic settings, despite many similarities of symptoms and blood test results. This reinforces the need for more research directed to diagnostic methods for CEBV. Doctors have recently become aware of a fairly large number of patients in San Francisco who may be afflicted with this illness. A group of about 40 will be included in the studies.

I believe the events of the past two years partially answer the question, 'how many people have this disease?" As time goes on, more people are diagnosed as having CEBV. As yet, there is confusion regarding the type of testing for diagnosis, there is no routine treatment to alleviate the debilitating symptoms and much has to be done in research to find a cure.

However, the question of the incidence of CEBV will not be properly answered as long as the patients themselves must seek ways of finding out this information. There must be a definite medical protocol set up at National Institutes of Health and/or Centers for Disease Control so that physicians will scientifically report the incidence of the chronic form of the Epstein-Barr virus in their patients.

We ask this Committee to recommend:

1) That the National Institutes of Health, National Institute of Allergy and Infectious Diseases conduct or sponsor more research on the chronic form of the Epstein-Barr virus infection in the search of better techniques for diagnosis, treatment and, hopefully, an eventual cure.

2) That a protocol be established through:

National Institutes of Health or
Centers for Disease Control

for reporting the incidence of the chronic form of the Epstein-Barr virus by physicians. This reporting should be set up as a clearing-house of medical information to assist physicians, researchers and patients.

Research will lead to better means of diagnosis of this illness, greater dissemination of medical information to the medical community, some form of treatment to alleviate at least some of the debilitating symptoms and, hopefully, an eventual cure of this disease which afflicts the lives of so many of our citizens.

ADDENDUM A

Re: Research and Reporting Protocol Needs for Chronic Active Epstein-Barr Virus Infection (CEBV)

Data from the Doreen Clark Survey revealed:

> In patients who have been ill 2 years or more, 80% reported typical symptoms: extreme debilitating fatigue/exhaustion; muscle aches; sore throat; headaches; difficulty in concentrating; dizziness; depression and irritability. Extreme fatigue was reported to be constant and unrelieved by 64% of the patients.
>
> 71% of the patients were in the age group 24 to 44 years old and 75% were female. 75% have attended or graduated from college.
>
> 46% reported that they had been ill with CEBV 2 to 5 years; 24% from 5 to 10 years; and 30% over 10 years. 22% of the patients said other members of their family also have CEBV.
>
> 33% reported that they had been denied Social Security disability benefits. Many others indicated that they had been discouraged from filing because they were told the application would be rejected 'because CEBV is not a recognized illness for disability.'

In reviewing the survey, CEBV research physician, Anthony L. Komaroff, M.D., Chief of General Medicine, Brigham & Women's Hospital, and Harvard Medical School, commented that the number of patients over the age of 45 was substantial. Also, the number of patients who had many of the symptoms which they described as 'severe' was quite great. He said that it was encouraging that a large percentage (90%) of the patients said that they would be willing to participate in research.

Dr. Komaroff suggested that it would be important to assess the responses of the 702 survey patients who have at least one positive titers blood test by surveying these patients and their doctors regarding the actual results of the EBV serological panel and the laboratory which performed the testing. This would be an extremely valuable way of determining how this diagnosis currently is being made by doctors, how solidly the diagnosis seems to be based, and would identify those laboratories which are most involved in performing such testing.

NATIONAL INSTITUTE OF ALLERGY & INFECTIOUS DISEASES

Current studies indicate a nationwide increasing incidence of a physically and psychologically disabling illness, Chronic Epstein-Barr Virus Infection (CEBV). NIH should expand research studies on CEBV to improve diagnostic techniques, develop treatment, and search for an eventual cure of this debilitating illness which is affecting thousands of our citizens.

CENTERS FOR DISEASE CONTROL

Chronic Epstein-Barr Virus Infection (CEBV), a debilitating illness, is affecting an increasing number of people across the U.S.A. The incidence appears to be much higher than was previously indicated. There have been apparent small epidemics of this disease in various parts of the country and reports of thousands of individual cases. The CDC should establish a protocol or surveillance network for reporting the incidence of the chronic form of the Epstein-Barr virus by physicians, and serve as a clearing house for medical information to assist physicians, researchers and patients.

MONDAY, APRIL 28, 1986.

NIH

WITNESS

DR. MARGARET A. KRIKKER, PRESIDENT AND FOUNDER, THE HEMOCHROMATOSIS RESEARCH FOUNDATION, INC.

Mr. NATCHER. Our next witness is Dr. Margaret A. Krikker. Come around, Dr. Krikker.

Dr. KRIKKER. I am an Albany, New York family physician, founder and President of the Hemochromatosis Foundation. I request that my prepared written statement be made a part of the committee record. My appearance today is on behalf of the Research Foundation, and our members include physicians, patients, laity and an international board of 25 world-renowned researchers and clinicians representing disciplines of all the various systems affected by hemochromatosis, which is an iron-overload disorder.

My testimony today concerns the requested appropriations of the Administration, the cuts not be approved, but rather an increase in the funding of the National Institutes of Health be appropriated to the tune of $5,200,000,000.

Also, a request that the research for hemochromatosis be expanded and continued this year. I do not have the exact figures of the past appropriations for hemochromatosis, but unquestionably, with the reduced appropriations, hemochromatosis research as well as other research will be curtailed.

Hereditary hemochromatosis is a unique disorder. In this disorder, individuals absorb too much iron from the diet. With early diagnosis, a full, normal life span is possible, with a diagnosis.

Without a diagnosis, these individuals develop all the chronic usual disorders affecting Americans, which are diabetes, heart disease, disabling arthritis, liver sclerosis and cancer.

Since the mid-seventies, with the advent of modern biomedical and genetic research tools, or researchers have made major contributions of our present knowledge of iron metabolism and hemochromatosis.

Their studies of pedigree families with hemochromatosis in Australia, Europe and in this country have made it possible to estimate that there may be 600,000 to 1,000,000 affected Americans, which makes this the absolutely most common disorder in this country, and more common than cystic fibrosis, with an affected population of 100,000, and a carrier rate of 10,000,000, and with hemochromatosis, the carrier population is 24 to 32,000,000.

This is an extraordinarily high gene frequency. As stated by a Mayo researcher in 1971, hemochromatosis provides an unparalleled opportunity for the prevention—for the practice of preventive medicine at its best.

There are many gaps in knowledge, and one very important research tool which, if it were developed, finding a simple, inexpensive test to diagnose early hemochromatosis affected patients would unquestionably reduce the increasing incidence of cardiovascular disease, diabetes, disabling arthritis, cancers, and other disorders.

The reduction of these disorders would also result in cost containment of the medical care of these individuals. The tremendous cost to families, welfare agencies, and government, and an additional bonus would be an increased blood supply to the blood banks, because the treatment in this disorder is being bled periodically as in a blood donation, hemochromatosis is not a blood disorder, the blood is very usable and there is no prohibition against the use of it by FDA or by New York State from where I come.

Although much knowledge has been gained about this disease, there are remaining serious gaps, and unless the Administration's cuts are restored, and additional funds appropriated, serious research will be curtailed.

As I stated, I am not privy to the research funding which would be affected by the cuts, but undoubtedly, there would be cuts. In conclusion, I would like to urge the subcommittee to increase the appropriations for the National Institutes of Health to 5,200,000,000.

Further, since hereditary hemochromatosis affects multi-disciplinary systems, financial support for research in hemochromatosis be shared among the various National Institutes of Health involved with diseases of the heart, liver, pancreas and other hormonal glands, joints, cancer and immunology.

Further, I request the committee to appropriate the funds for these various Institutes of Health dealing with these disorders.

I thank you.

Mr. NATCHER. Thank you very much, Dr. Krikker. We appreciate your appearance. You made an excellent statement.

[The statement of Dr. Krikker follows:]

Cover Page
plus six pages text

Scheduled Date: April 28, 1986
" Time: 2:15 P.M.

STATEMENT OF

MARGARET A. KRIKKER, M.D.,
PRESIDENT

OF

THE HEMOCHROMATOSIS RESEARCH FOUNDATION

BEFORE

THE SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES
AND EDUCATION APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES

CONCERNING

FISCAL YEAR 1987 APPROPRIATIONS FOR THE NATIONAL INSTITUTE OF HEALTH

SUMMARY OF RECOMMENDATIONS

1. It is requested that appropriations for the National Institutes of Health be increased to $5,200,000,000.
2. That, since Hereditary Hemochromatosis (H.H.) affects multidisciplinary systems, financial support for the disorder be shared among the various National Institutes of Health involved with diseases of the heart, liver, pancreas and other hormonal glands, joints, muscle, skin, cancer and immunology.
3. It is requested that the appropriations for the National Institute of Diabetes, Digestive Disorders and Kidney Diseases for the Fiscal Year 1987 be increased to $503,000,000.
4. It is requested that the appropriations for the National Institute of Health for Arthritis, Musculoskeletal and Skin Disorders for the Fiscal Year 1987 be increased to $116,000,000.

Mr. Chairman and Members of the Subcommittee:

For the record, I am Margaret A. Krikker, an Albany family physician and president and founder of The Hemochromatosis Research Foundation. I would like, first, to thank you for the privilege and opportunity of testifying before your Subcommittee on behalf of the Foundation (1) for the purpose of supporting an increase in appropriations for Fiscal Year 1987 for the National Institutes of Health, and (2) to request that financial support for research in hereditary hemochromatosis (hereinafter referred to as H.H.) be continued and increased during 1987. (I do not know the amounts allocated during 1986 but, judging from the 1987 budgetary requests for the various National Institutes of Health, the appropriations will most likely be less than those for 1986).

WHAT ARE THE GOALS OF THE HEMOCHROMATOSIS RESEARCH FOUNDATION?

The Hemochromatosis Research Foundation is a not-for-profit organization, founded in 1982, for the major purposes of increasing the awareness of physicians and the public about H.H., to encourage the routine screening of Americans by physicians, in hospitals, at fairs, blood banks, or wherever possible, so as to identify H.H. individuals and their families, and to solicit funds for screenings and for research and,with growth of the foundation, to support education of and research in iron metabolism and hemochromatosis.

WHAT IS HEREDITARY HEMOCHROMATOSIS?

I shall briefly review what H.H. is even though I am aware that the members of this Subcommittee have been made aware of the disorder by the "Dear Colleague" letter written in June 1985 by one of your members, The Hon. Senator Alfonse D'Amato, together with The Hon. California Representative, Vic Fazio, concerning a Joint Resolution to have April 13-19, 1986 proclaimed as Hemochromatosis Awareness Week. (Due to insufficient co-sponsorship, a 1986 Awareness Week did not materialize, but I am hopeful that it will in 1987)*

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* A New York State Hemochromatosis Awareness Week did materialize and is being commemorated this week, including a Teaching Day in Hemochromatosis Friday, April 18, 1986.

H.H. is a disorder of iron metabolism in which dietary-iron absorption exceeds body needs, from birth on. Since there is no effective excretory mechanism to rid the body of iron once it is absorbed, except by bleeding, excess iron accumulates gradually and silently in the vital organs: liver, heart, pancreas, pituitary and other hormonal glands, as well as in joints, muscle and skin. Because early symotoms are non-specific and resemble those in many other medical conditions (fatigue, listlessness, weight loss, joint pains, decreased sex drive and abdominal discomfort,)early diagnosis is rarely made, unless H.H. is specifically thought of by an astute physician and the appropriate screening tests performed. An early clue, when present, is that of a tan not due to sun-exposure. More advanced symptoms are those of the organs damaged: liver enlargement (prior to the development of cirrhosis and often cancer), diabetes and other hormonal deficiencies, heart arrhythmias and congestive failure, impotence, occasionally menapause in very young women, and arthritis. Most patients do not have all these problems; symptoms are variable.

H.H. COMPLICATIONS OF UNDIAGNOSED H.H. ARE THOSE OF THE MAJOR CHRONIC DISABILITIES AND CAUSES OF DEATH IN USA

The complications resulting from a delay or a misdiagnosis of H.H. are those of the major chronic disabilities (heart and liver diseases, diabetes, cancers, arthritis) affecting Americans, and early deaths.

HOW COMMON IS H.H.?

Prior to the mid-70's H.H. was considered to be rare and to affect about 20,000 Americans. With the advent of modern biomedical and genetic research tools, however, more accurate estimates indicated that H.H. was probably the most common genetic disorder, affecting 3-8/1,000 Caucasions, and a carrier rate of 10-16%. Based on the statistics of 300,000,000 Caucasions, there may be affected 600,000 to 1,600,000 Americans -- most of whom are unaware of their genetic predisposition to load and damage their vital organs and joints with iron -- and 24 to 32 million carriers. This makes H.H. MORE COMMON THAN CYSTIC FIBROSIS (100,000 affected, with a ten million carrier population) or sickle-cell anemia (50,000 affected).

HEMOCHROMATOSIS: THE NEGLECTED DIAGNOSIS

H.H. is not only the most common genetic disorder but, as a review of the medical literature indicates, it is also another genetic disorder that is rarely diagnosed before clinically manifest, or even when clinical signs and symptoms are present, i.e., arthritis, heart disease, diabetes and other hormonal deficiencies, and enlarged liver. Sad to say, too many physicians still consider H.H. to be rare; and thefefore many patients with diabetes, heart problems, liver dysfunction and arthritis due to H.H. are not receiving essential and specific treatment to remove excess iron from their bodies, with unfortunate results of an early death sentence. In addition, blood relatives of such patients are also missing the vital opportunities of getting an early diagnosis and treatment.

In 1983, in preparation for a protocol covering a pilot screening study of apparently-healthy blood donors in the Northeastern New York region of the American Red Cross Blood Services to be conducted by our foundation, in cooperation with the regional American Red Cross services, I reviewed the area hospital records for the incidence of H.H. only to learn that my search supported the prevailing literature that preclinical and symptomatic H.H. was rarely being diagnosed. Further, the diagnosis was not being made at death either, according to my review of the New York State Health Department's Bureau of Vital Statistics for the years 1978-1982. Surprisingly, there were no deaths attributed to H.H. in any of the 14 counties of the region, with the exception of the year 1978, when seven deaths were reported: one in Albany County (that of my husband) and six others in nearby Schenectady county.

More recently, from my reviews of Foundation patient-questionnaires and my correspondence with them, they substantiate further the problems of diagnosis. There are repeated stories of diagnoses made of family members shortly before or at autopsies, of delays in diagnoses result in disabling irreversible complications.

Of relevance, Dr. Virgil Fairbanks, a Mayo Clinic researcher in iron metabolism wrote an article entitled "Hemochromatosis: The Neglected Diagnosis" appearing in the January 1986 issue of the Mayo Clinic Proceedings. Among given reasons for the neglect were that "... most clinicians still consider it (H.H.) a rare disease. Thus, hemochromatosis is often not diagnosed during life. This failure of detection is because hemochromatosis mimics other common diseases. It lurks unrecognized among patients with diabetes mellitus, congestive heart failure, 'idiopathic' cardiomyopathy, rheumatoid arthritis, alcoholic cirrhosis, or hypogonadism. ..."

BUT, H.H. CAN BE DIAGNOSED BEFORE SYMPTOMS OR
BEFORE ORGAN DAMAGE, AND A FULL, NORMAL LIFE POSSIBLE!

Ironically, diagnosis can be made early (even in childhood) before symptoms or before organ damage. And the prophylactic treatment of periodic bleedings (one pint as in a blood donation) will remove accumulated iron and prevent further accumulation and the resultant organ damage, and a normal, full life possible. Early treatment can also reverse existing damage, depending on of course the extent and severity of the complications present at the time of diagnosis.

FUNDING FOR H.H. RESEARCH URGENTLY NEEDED

In the last ten years, our understanding of iron metabolism of iron proteins, and the genetics of H.H. have increased tremendously. We now know that the mode of transmission of H.H. is autosomal recessive, and the gene defect responsible for H.H. has been mapped on chromosome six, on the short arm closely linked to

HLA-A allele of the HLA complex. There is, however, considerable need for funds for research aimed at (1) identifying the genetic defect or defects causing the increased iron absorption and at understanding the toxic effects of iron; and (2) there is urgent need of a simple, inexpensive test with which to identify the young hemochromatosis homozygote (bearer of the two H genes derived from each carrier parent) and the carriers (inheritor of one H gene); (3) iron and immunol

SUMMARY

1. Estimates show that H.H. is the most common genetic disorder;
2. H.H. is not generally being diagnosed
3. H.H. complications are those of the major causes of chronic disability and death of Americans, and those complications are contributory to the increasingly high cost of medical care
4. Continued and increased H.H. research appropriations are urgently needed.
5. Increased H.H. funding will benefit with knowledge about H.H., earlier detection of H.H., and will result in cost-containment of the medical care of heart disease, diabetes, disabling arthritis, liver cirrhosis and cancers.

RECOMMENDATIONS:

1. It is requested that appropriations for N.I.H. for Fiscal Year 1987 be increased to $5,200,000,000.
2. That, since H.H. affects multidisciplinary systems that financial support for the disorder be shared among the various National Institutes of Health involved with diseases of the heart, liver, pancreas and other hormonal glands, joints, muscle and skin, also immunology.
3. It is requested that the appropriations for the National Institute of Diabetes, Digestive Disorders and Kidney Diseases for the Fiscal Year 1987 be increased to $503,000,000
4. It is requested that the appropriations for the National Institute of Health for arthritis, musculoskeletal and skin disorders for the Fiscal

WHY MY INTEREST IN HH? - PERSONAL .

Aware that my husband had an undiagnosed ailment, I resumed college and entered medical school six years after my marriage. Then, as a second-year med student studying H.H. liver slides, I suspected my husband's huge liver and symptoms (weakness, abdominal, chest and joint pains) and a tan not due to sun-exposure) could be due to H.H. My suspicious were subsequently substantiated. At that time (1946), the bleeding treatments were not yet available. By the time they were, in the early 1950's, he had extensive organ damage involving his heart, liver, pancreas, pituitary, thyroid and adrenal glands, heart arrhythmias and uncomfortable hands, feet, knees and shoulders. Then, a coronary occlusion, with cardiac arrest AND open-chest resuscitation (closed-chest massage not yet routine) miraculously recovered. This was 1956. He returned to his work as research chemist and able to continue much original work. Against medical advice, however, he returned to tennis, skiing, bicycling, hiking and lived to enjoy life for 20 years longer! And, in the last year of his life, while playing tennis on two occasions had cardiac near-fatal emergencies. His death was due to a 2nd coronary and irreversible arrest in his 70th year. His joie de vivre, his personal drive and sense of humor sustained us both...

One has to live with H.H. to appreciate the psychologic and emotional impact, the tremendous financial sacrifices, and much more.

MONDAY, APRIL 28, 1986.

NATIONAL INSTITUTES OF HEALTH

WITNESS

JAMES R. ISON, CHAIR COUNCIL OF GRADUATE DEPARTMENTS OF PSYCHOLOGY

Mr. NATCHER. Our next witness is Dr. James R. Ison. Come around, Doctor. We are glad to have you before the committee at this time. We we will be pleased to hear from you.

Mr. ISON. Mr. Natcher, ladies and gentlemen.

I am Professor James R. Ison, Chair of the Department of Psychology at the University of Rochester. I am here today to testify as the Chair of the Council of Graduate Departments of Psychology, COGDOP.

I represent over 300 graduate departments of psychology at colleges and universities around the country, including all of the major research universities and many medical centers and schools of education located in every State. I am very pleased to be here to testify on the subject of the National Institutes of Health appropriations.

In my prepared remarks, I have included specific funding recommendations for several of the NIH Institutes, including the National Institute of Child Health and Human Development, the National Institute on Aging, the National Institute of Environmental Health Sciences, the National Heart, Lung, and Blood Institute and the National Cancer Institute.

I will not discuss these detailed recommendations at this time, however, I would like to point out that every NIH Institute has a very important obligation to study the behavioral aspects of health promotion and disease prevention.

This committee is to be especially commended because of your insightful recognition of the importance of this new area of scientific work, an area that you have described in your appropriations reports for the last two years.

Two recent reports, the Surgeon General's report, "Healthy People," and the Institute of Medicine's report, "Health and Behavior," document that seven of the 10 leading causes of death in this country are in large part behaviorally determined and can be significantly reduced through changes in behavior.

Heart disease, cancer, high blood pressure, and even infectious diseases, all have environmental contributions. In fact, we believe that inappropriate behavior, directly or indirectly, is the Nation's biggest killer, products its most debilitating illnesses, and causes the greatest number of injuries in this country.

Yet, the National Institutes of Health, the Nation's largest source of funding for health research, has recently estimated that it spends less than 3 percent of its total budget in the areas of behavioral and social science research.

Given the growing appreciation of behavioral factors in health promotion and disease prevention, COGDOP recommends substantially increasing the percentage of NIH funds presently spent on health and behavior research.

In addition, COGDOP recommends an increase in the number of research trainees supported by NIH. Research training is absolutely necessary to maintain the vitality of all scientific disciplines, and cuts in research training funds at NIH will lead to severe shortages of adequately-trained teachers and researchers over the next decade.

In a 1985 report on the personnel needs for biomedical and behavioral sciences, the Institute of Medicine advocated increased Federal support specifically for behavioral science research training, demonstrating their understanding of the great importance of this new area of basic and applied research.

COGDOP asks the committee to support increased funding for NIH research training and we strongly urge the committee to specifically direct NIH to implement the recommendations of the IOM to increase funding for research training in the behavioral sciences.

COGDOP is especially concerned about the Administration's proposed elimination of NIH's $60,000,000 Biomedical Research Support Grant Program. BRSG funds are designed to augment the resources of institutions heavily engaged in health-related research, and is traditionally used to fund young investigators and innovative multi-disciplinary research.

The $60,000,000 contained in this year's NIH budget for this program will be distributed to a total of 576 institutions, and we estimate that one-fifth of the total will assist behavioral and social science researchers.

These funds are very important to new investigators with new ideas, and for these reasons, COGDOP strongly urges Congress to restore funding for the BRSG program at NIH.

There is one final critical NIH funding issue about which COGDOP has very serious concerns: OMB's recent unilateral action to cap universities' reimbursement for the indirect costs of research grants.

We strongly object to the arbitrariness of the proposed caps on the administrative portion of indirect costs. We were pleased that OMB agreed to delay implementation of these changes for a few months, and feel that it is now imperative for OMB to negotiate with the affected parties before implementing these major changes.

We ask the committee to monitor this serious situation, and to ensure that all parties are given a reasonable opportunity to discuss with OMB the implications of the proposed cap on indirect costs.

Thank you, Mr. Chairman, for the opportunity to present the views of the Council of Graduate Departments of Psychology on NIH appropriations issues.

[The statement of Mr. Ison follows:]

TESTIMONY OF

James R. Ison, Ph.D.

Chair, Department of Psychology

University of Rochester

on behalf of

COUNCIL OF GRADUATE DEPARTMENTS OF PSYCHOLOGY

before the

U.S. HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

COMMITTEE ON APPROPRIATIONS

on the subject of

NATIONAL INSTITUTES OF HEALTH APPROPRIATIONS

Fiscal Year 1987

April 28, 1986

The Honorable William H. Natcher, Chair
2358 Rayburn House Office Building

Mr. Chairman and Members of the Subcommittee,

I am Professor James R. Ison, Chair of the Department of Psychology at the University of Rochester. I am here today to testify before this Committee as the Chair of the Council of Graduate Departments of Psychology (COGDOP). COGDOP represents over 300 graduate departments of psychology at colleges and universities around the country, including all of the major research universities, and many medical centers and schools of education located in every state. I am very pleased to be here on behalf of COGDOP to testify on the subject of the National Institutes of Health (NIH) FY 87 Appropriations.

Health and Behavior

Two recent reports, the Surgeon General's report "Healthy People" and the Institute of Medicine's report "Health and Behavior", document that 7 of the 10 leading causes of death in this country are in large part behaviorally determined and can be significantly reduced through changes in behavior. Heart disease, cancer, high blood pressure, and even infectious diseases -- all have environmental causes. In fact, we believe that inappropriate behavior, directly or indirectly, is the nation's biggest killer, produces its most debilitating illnesses, and causes the greatest number of injuries in this country. Yet, the National Institutes of Health (NIH), the nation's largest source of funding for health research, has estimated that it spends less than 3% of its total budget in the areas of behavioral and social science research. This minimal figure is especially disturbing in light of the overwhelming data on the behavioral causes of ill health. COGDOP strongly supports substantial increases in spending on important behavioral research at NIH in FY 87.

We urge the Committee to continue its support for research into the important relationship between health and behavior. Last year, this Committee included in its report accompanying the FY 86 Appropriations bill language in support of health and behavior research at NIH. Also included was a specific request that NIH "review research grants related to the link between health and behavior awarded by each Institute during the past three years, and report to the Committee on where research initiatives in this area have occurred, the total funding for health and behavior research over this period for each Institute, and future priorities at each Institute for behavioral research." In response to this request, NIH recently submitted a report which estimated that a total of $105.3 million was spent on health and behavior research in 1985 throughout its Institutes. This figure is $32.2 million less than the estimate that was given by NIH Director Dr. James Wyngaarden at last year's NIH appropriation's hearings before this Committee. Given the primary importance of behavioral factors in health promotion and disease prevention, COGDOP recommends increasing the percentage of NIH funds presently spent on health and behavior research by at least 10% in FY 87. We urge the Committee to continue its active support of health and behavior research at NIH.

NIH Research Budget

COGDOP strongly urges the Committee to increase the research budget at NIH to fund at least 6500 new and competing research grants in FY 87. We greatly appreciate the strong support of this Committee in the past for increasing badly needed research funds at NIH. The Administration's FY 87 budget request for NIH is $4.9 billion, a $500 million cut from the FY 86 level appropriated by this Committee. This FY 87 budget proposal would fund only 5,104 new and competing research grants, a decrease of 969 grants from the level recommended by Congress for FY 86, and an even greater cut of 1,115 from the number of new and competing research grants funded by NIH in FY 85.

This reduction in grants is the starting point for the Administration's proposal for a new grant stabilization policy to achieve a constant number of 18,000 total grants at NIH over the next several years. COCDOP is opposed to such a reduction in grant numbers in order to "stabilize" the total grant figure. This policy will severely limit the development of this new and critical field of health and behavior. In effect, it would lower the baseline number of grants for budget considerations for years to come, and is contrary, even antagonistic, to the past efforts of Congress to increase the numbers of new and competing grants at NIH as the need for more basic research in health-related issues increases. We encourage the Committee to reject this latest attempt by the Administration to lower the baseline for new and competing research grants at NIH and to fund at least 6500 grants for FY 87.

NIH Research Training

COGDOP recommends a substantial increase in the number of research trainees supported by NIH in FY 87. The Administration's FY 87 budget request for NIH research training is $198.2 million. This figure would support only 9,250 predoctoral and postdoctoral trainees in FY 87, a substantial cut from the 10,623 trainees who would have been funded by the FY 86 appropriated levels for research training. Research training is vitally important to maintaining the vitality of all scientific disciplines, and cuts in research training funds at NIH will lead to severe shortages or adequately-trained researchers over the next decade.

In a 1985 report on the personnel needs for biomedical and behavioral sciences, the Institute of Medicine (IOM) advocated increased federal support for behavioral science research training. This recommendation was made, for the most part, because of the scientific and practical value of this new field of health and behavior. More specifically, the report recommended increased federal support at the predoctoral level in behavioral research. COGDOP asks the Committee to support increased funding for NIH research training in FY 87, and we strongly urge the Committee to specifically direct NIH to implement the recommendations of the IOM to increase funding for predoctoral research training support in the behavioral sciences.

Biomedical Research Support Grant (BRSG) Program

COGDOP is especially concerned about the Administration's proposed elimination of NIH's $60 million Biomedical Research Support Grant program. BRSG funds are designed to augment the resources of institutions heavily engaged in health-related research, and is traditionally used to fund young investigators and innovative multi-disciplinary research. The future for many young investigators is already uncertain due to deficit reduction measures -- the elimination of the BRSG program at this time would be especially devastating. The $60 million contained in the FY 86 NIH budget for the BRSG program will be distributed to a total of 576 institutions, and we estimate that $12.25 million, one-fifth of the total, will assist behavioral and social science researchers. We are very concerned about the proposed elimination of the BRSG program which has been of such critical assistance to many young investigators engaged in important health-related research. COGDOP strongly urges Congress to restore funding for the BRSG program at NIH.

National Institute of Child Health and Human Development (NICHD)

The NICHD was established as part of NIH in 1962 with a mandate to promote the healthy development of children, from the prenatal period into adulthood. As such, NICHD supports important research on the psychological, social, biological, and environmental factors that influence the course of human development. Current research emphases at NICHD include teenage pregnancy and childbearing, childhood injury prevention and the origins of risk-taking behavior, intellectual and emotional development in the family and school setting, and the role of behavioral and biological factors in normal and high-risk pregnancy and birth.

In most respects, NICHD is working successfully to fulfill this mandate. This progress is threatened, however, by the $309.1 million budget proposed by the Administration for FY 87, $13 million below the FY 86 level appropriated by Congress. Under the FY 87 proposal, new and competing research grants at NICHD would be reduced in number from 483 in FY 86 to 456 for FY 87. Research centers would be hit particularly hard, bearing a 16 percent across-the-board cut. Research training at NICHD would fall well below the 1985 level of 702.

To continue its important work, NICHD must be funded at a reasonable level. COGDOP urges the Committee to support an increase to $376.7 million for the NICHD research budget in FY87. This budget would provide support for 630 competing research grants, which would represent a funding rate of approved grants equal to the overall NIH rate of 34%. This budget would also restore research training funds to the 1985 level of 702 full-time training positions. We would also urge Congress to encourage NICHD to strengthen their commitment to behavioral science research by allotting a larger portion of grants and grant dollars to behavioral and social science research projects.

National Insititute on Aging (NIA)

The National Insititue on Aging (NIA) is the major source of federal funding for biomedical and behavioral research in aging. NIA's mission is to increase the knowledge of the aging process and associated physical, psychological, and social factors related to advanced age. Current research emphasis at NIA includes the diagnosis, etiology, clinical course, prevention and treatment of Alzheimer's disease, one of the leading causes of severe intellectual impairment in the elderly; cognitive aging and its impact on intelligence, learning ability, memory, and sensory-motor functioning; behavioral geriatric studies into health promoting behavior; and the health problems and social factors associated with minority elderly.

At a time when the aging population in this country is increasing and when NIA is making progress in many areas of aging research, the Administration has submitted a budget request for FY 1987 of $145.8 million, a reduction in the the NIA budget by $11 million from the FY 86 level appropriated by Congress. Under this proposal, competing extramural grants would be decreased from 201 to 145, research training awards decreased from 240 to 195, and support for the 12 research centers (ten of which are Alzheimer's Disease Research Centers) decreased by $600,000. These reductions would have a detrimental impact on NIA's ability to continue its research mission.

To continue its important work, NIA must be funded at a level that allows for needed growth of the Institute. COGDOP strongly recommends that NIA's FY 1987 research budget be fully funded to at least the FY 1986 appropriated level of $157.7 million to provide for needed growth in its vital research programs.

National Institute of Environmental Health Sciences (NIEHS)

The National Institute of Environmental Health Sciences supports research on the effects of exposure to toxic substances. The Administration proposal for the NIEHS research budget in FY 87 is $188 million, a decrease of $9.4 million from the level appropriated by Congress for FY 86. Many of the most severe effects of toxic exposure include damage to the central nervous system. Such damage may lead to tragic psychological changes, including sensory, cognitive and emotional changes -- exposed individuals may become blind, mentally retarded or psychotic. There is so much to be learned from behavioral research into the effects produced by exposure to toxic substances. COGDOP urges the Committee to direct NIEHS to increase funding in the area of behavioral research.

National Heart, Lung, and Blood Institute (NHLBI)

The National Heart, Lung, and Blood Institute supports more behavioral research than any other NIH Institute. As I previously mentioned, the important link between behavior and the prevention of such diseases as heart disease, high blood pressure and lung diseases has been documented in two nationally recognized reports by the Surgeon General and the Institute of Medicine. The Administration's proposed research budget for FY 87 at NHLBI is $785.7 million, a substantial $62.3 million cut from the FY 86 appropriated level. This drastic cut in NHLBI research funds would not allow for important behavioral research into such important issues as the how behavior affects the development of some of this nation's major causes of death. We are all aware of the affect of smoking cessation in relation to the development of lung diseases -- changes in lifestyle can also play a role in preventing or controlling hypertension, asthma, and coronary disease. COGDOP strongly recommends increasing the research budget at NHLBI to at least the FY

86 appropriated level of $848 million.

National Cancer Institute (NCI)

The goal of the National Cancer Institute is to reduce cancer incidence, morbidity, and mortality. Cancer, again, is an example of a disease which is affected substantially by behavioral factors -- an individual's occupation, diet, and whether or not he or she smokes can increase the risk for developing cancer. Behavioral scientists have a major role to play in the prevention of cancer through research into these important behavioral influences. The Administration's FY 87 budget request for NCI is $1.158 billion, a reduction of $68 million from the FY 86 appropriated level. COGDOP requests the Committee to encourage NCI to greatly increase its support of behavioral research, particularly in the area of cancer prevention. We support a research budget for NCI of at least the FY 86 appropriated level of $1.226 billion.

There is one other critical NIH funding issues about which COGDOP has very serious concerns:

Indirect Costs

COGDOP is concerned about OMB's recent actions to cap universities' reimbursement for the administrative portion of indirect costs of research grants at 26% for FY 86 and at 20% for FY 87. While we certainly agree with the need to control the costs of federally funded research, including that **research funded by NIH, we strongly object to the arbitrariness of the proposed caps on the administrative portion of indirect costs. We were** pleased that OMB agreed to delay implementation of these changes to OMB Circular A-21 for a few months, and feel that it is now imperative for OMB to listen to the affected parties, the universities, before implementing these major changes. I would like to point out that the proposed revisions in A-21 would affect the indirect cost rates for universities only. Private sector indirect cost rates, which are significantly higher than universities, will not be affected by this proposal. We ask the Committee to monitor this serious situation, and to ensure that all affected parties are given a reasonable opportunity to discuss with OMB the implications of the proposed cap on indirect costs.

Thank you for the opportunity to present the views of the Council of Graduate Departments of Psychology on NIH Appropriations issues. I will be happy to answer any questions you may have, or to supply the Committee with further information on any of the issues I have discussed.

Mr. NATCHER. Dr. Ison, it has been a pleasure to have you before the committee.

MONDAY, APRIL 28, 1986.

NICHD, NIDDKD

WITNESS

DR. CLAUDE MIGEON, PROFESSOR OF PEDIATRICS, THE ENDOCRINE SOCIETY

Mr. NATCHER. Our next witness is Dr. Claude Migeon. We will be pleased to hear from you at this time.

Dr. MIGEON. Thank you, Mr. Chairman. Thank you for permitting me to come and testify before you. I am a Professor of Pediatrics at Johns Hopkins University School of Medicine, and I represent the Endocrine Society, an association of over 4,000 members who are interested in the study of hormones and in the treatment of hormonal disorders.

Disorders of the endocrine system have a great impact on health and as a consequence on medical costs. They result in abnormalities of sexual differentiation in infants and adolescents, in infertility and multiple sexual dysfunction.

Decreased or increased thyroid function are frequent problems. Diabetes and its complications are most troublesome. Osteoporosis resulting in bone fractures takes an awesome toll on aging subjects.

It must be noted that hormonal abnormalities are involved in atherosclerosis, hypertension, certain cancers and some psychoses. The extent and diversity of endocrine or endocrine-related diseases demonstrate the need for further investigation in this field.

Endocrinologic research is mainly supported by the National Institute of Diabetes and Digestive and Kidney Diseases and the Reproduction Branch of the National Institute of Child Health and Human Development. It is also supported to variable degrees by all the other Institutes. This permits us to be less parochial than other areas of research and to support the overall efforts of NIH.

We feel cuts in this area would be very terrible, and we, therefore, recommend and ask to try to get a total budget for the NIH, for biomedical research for $6,079,000,000 for 1987, and which would provide for current services plus a very modest 1.4 percent increase for special programs or initiatives.

In many Institutes, the rate of grant awards made in relation to the total number of research projects which have been approved has fallen below 25 percent. It is clear that a great deal of biomedical advances are being lost because 75 percent of the projects approved are not funded.

We recommend that adequate funds be provided for the funding of at least one-third of all approved new and competitive RO1 grants. This would include $504,000,000 for NIDKK.

Research training: We recommend that special attention be given to the importance of training the investigators of the future. Training continues to be the best long-term investment we can make.

It may be too obvious, but the spigot of researchers cannot be easily turned on and off. Five to seven years of hard work and education is critical. If we continue to send mixed signals, we will only discourage, if not eliminate this resource.

Equipment and instrumentation:

This is one of the most costly yet most critical parts of research. The technology explosion centers right on research. Many types of new equipment make a great deal of research possible. Just as importantly, proper equipment can dramatically speed up the research we are doing.

We would urge you to continue the past initiatives in funding this area.

Construction and renovation:

Construction and renovation is a scary topic simply because of the need, which is estimated at $2,000,000,000 to $4,000,000,000. Some points are evident, however:

Many of our facilities which were built in the 1950s and 1960s are slowing down our research progress as much as not having the equipment or trainees.

We would recommend a program of $200,000,000 in fiscal year 1987 to get the process started. We would also recommend that there be an equal match of Federal to private dollars as a requirement for any project to prove the intent and need of those applying.

This formula would then mean that the $200,000,000 Federal investment would equate to $400,000,000, not to mention the tremendous numbers of both short and long-term jobs created.

Flexibility at the NIH:

Recent directives and actions by the NIH, the Secretary and OMB seriously impinged upon the ability of the individual Institutes and their Councils. In particular, we would urge you to adopt bill language restoring this flexibility to the individual Institutes.

Report language will not work. Very strong language was used last year, and OMB and the Secretary's Office completely ignored it.

In summary, we urge you to continue a strong medical research program and not fall to the whims of short-term budget problems. At a time when in 15 months, we are spending more on defense research and development than we have spent in our history on medical research, $6,100,000,000 for medical research as a percentage of health care costs than we were in 1977.

If we are ever to reach our goal to prevent and cure diseases, we must develop education, prevention and effective treatment programs. The only way to do that is through medical research.

I would like to bring a personal anecdote which happened at the Johns Hopkins Medical School, in our Department of Pediatrics. One mother of a young child who died at the hospital came to see our head of the Department and requested that he organize a meeting of the staff, and of the parents of children who had died at the Institute.

This was an unusual request. It sounded a little morbid as well, but for some reason, this is what this lady wanted. She invited all those people to come and as staff members, we attended.

It was a very emotional meeting. They had invited a rabbi from New Jersey, who had written a book on when bad things happen to good people, and he explained that he himself had lost a son at 14 years of age, and how, after 10 years later there was not one day when he didn't think in one way or the other of his son.

He explained to us that we could not weep, we, people on the staff, could never understand what the parents felt when they had lost their child, and this was probably true, but at the end, he turned to us and said, well, the reasons why the children died is because there was no cure for their disease, and this is up to you to try to work toward better medicine, and ways to take care of those diseases, prevent them and to possibly cure them.

It is clear from this fact which occurred, that it is very important to support biomedical research in this country. I thank you very much for your attention.

Mr. NATCHER. Thank you, Doctor, you made an excellent statement.

MONDAY, APRIL 28, 1986.

BIOMEDICAL RESEARCH

WITNESS

DR. CHARLES E. PUTNAM, CHAIRMAN, CONJOINT COMMITTEE FOR DIAGNOSTIC IMAGING

Mr. NATCHER. Our next witness is Dr. Charles E. Putnam. Dr. Putnam, we will be pleased to hear from you at this time.

Dr. PUTNAM. Mr. Chairman and members of the committee, I am Charles Putnam, Vice Chancellor for Health Affairs of Duke University Medical Center, and Vice Provost of Duke University.

I am extremely grateful for the privilege of representing the Society of Academic Radiology Chairmen and the Association of University Radiologists concerned with commitments to biomedical research, education and other health-related matters.

Radiology has experienced more dramatic changes in the past 20 years than any other specialty in the field of medicine. Medical imaging procedures account for, or contribute directly to, the final patient diagnosis in over 75 percent of all hospital admissions.

In addition, diagnostic radiographic examinations, or more broadly stated, medical uses of radiation, account for the vast majority of the human annual exposure to radioactive sources.

Though representing one of the more innovative disciplines which is at the frontier of new technologies expanding basic and clinical research and with a unique and focused impact on the diagnosis and therapy of disabling and life-threatening diseases, I would like to forego parochial wisdom, and restrict any further comments to some of the generic concerns that the Research and Academic Health Care Centers are facing together.

Most of us are products of the goodwill, generosity and encouragement of the Federal granting process. We have been the benefactor of a system which has allowed educational loans for the training of fellows, acquisition of scientific equipment, and dollars to support basic, applied and clinical research programs.

We have, with your immense help, and the leadership of your sponsoring bodies, the National Institutes of Health, providing for our mutual constituency, the public, a system of intellectually honest, industrious, and sensitive scientists who struggle to solve the complexities of a myriad of diseases, whether it be through early detection, eradication or by providing new and efficacious therapeutic interventions.

At times, our efforts seem to pale in comparison to our obstacles, whether it be Alzheimer's disease, Acquired Immune Deficiency Syndrome, malignancy, arthritis, or cardiovascular disease.

Yet, by your own knowledge and experience, and through the expressions of other speakers before you, attest to our successes as well as to our limitations and challenges.

At times, you may see us as an independent group of individuals, each representing a particular institution, public or private, with differing problems and solutions, an M.D. or a Ph.D. with differing roles and responsibilities, a bench researcher or a bedside clinician with perhaps opposing views and aims, a diagnostician or one principally trained for a therapeutic role, a generalist or someone very subspecialized.

Our research may appear at times esoteric; at other times it would appear to be mundane. Too often it is true, we emphasize our passion for scientific success, adhering to the Disease-of-the-Month-Club syndrome.

Though our efforts may appear to be fragmented, we share in common a commitment to the future generation of medical scientists and the responsibility to seek answers for those diseases that thus far have escaped our ability to diagnose and successfully treat.

The process of allocating public revenue, responding to the Federal deficit, and providing for the general safety and well-being of all American citizens does not need irrational or compromising recommendations from the scientific medical community.

The process and the challenges: In summary, one, we must maintain the highest regard and respect for the peer review system. It has served the biomedical community and public well, and should not be replaced by an arbitrary substitute, regardless of its best intention.

Two, educational allowances, regardless of the level, must be maintained and strengthened. Pre-doctoral and post-doctoral opportunities for present and future clinicians and scientists are the best investment for ultimately acquiring needed solutions.

Three, our institutions and organizations, along with the Federal supporting Institutes and agencies, must renew a mutual commitment to support and strengthen the role of the individual clinical and basic scientist.

Collective and multi-disciplinary efforts are necessary for many programs and initiatives, but the best of these succeed when individual prerogatives and creativity are able to flourish.

Four, we uniformly support the time-proven method of evaluating and support biomedical research. We specifically endorse the budgetary requests of the respective Federal Institutes and agencies.

Any differences we may have related to the distribution, priority or representation, can and should be resolve through the same mechanisms which allow for these deliberations.

Mr. Chairman, committee members, I thank you for this opportunity.

Mr. NATCHER. Thank you very much, Dr. Putnam. You have made an excellent statement. We appreciate your appearance before the committee.

MONDAY, APRIL 28, 1986.

NIH, ADAMHA

WITNESS

DR. WILLIAM K. RIKER, EXECUTIVE OFFICER, AMERICAN SOCIETY FOR PHARMACOLOGY AND EXPERIMENTAL THERAPEUTICS

Mr. NATCHER. Our next witness is Dr. William K. Riker.

Doctor, we will be pleased to hear from you at this time.

Dr. RIKER. Mr. Chairman, members of the subcommittee, I want to thank you for this opportunity to appear before you today to discuss funding for biomedical and biological research.

I am William Riker, a physician, a working scientist, and professor and Chairman of the Department of Pharmacology in the School of Medicine of the Oregon Health Sciences University. I am also President of the American Society for Pharmacology and Experimental Therapeutics, and it is in this capacity that I appear before you today.

The American Society for Pharmacology and Experimental Therapeutics is one of the seven constituent societies of the Federation of American Societies for Experimental Biology, a Federation which, by the way, represents 28,000 scientific researchers in the biomedical and biological sciences.

The Pharmacology Society is the national affiliation of pharmacologists working in universities, the pharmaceutical industry and government. And our major purpose is to generate and disseminate new knowledge about drugs, from the most basic levels of understanding their actions, to drug development, to clinical evaluations of their effects in patients.

In short, we work right at the interface between the laboratory bench and the bedside, with the goal of preventing and relieving sickness and disease.

For that reason, we, the Federation of American Societies for Experimental Biology, the Ad Hoc group, are vitally concerned about the appropriations bill that funds the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration.

You, Mr. Chairman, and your subcommittee have been outstanding in your support of basic biological research and we deeply appreciate your commitment. You have told HHS Secretary Bowen, and I quote, "Congress believes one of the most important and successful programs is NIH."

We, of course, share your belief, and we are asking now your help and support more than ever to insure that the funding level for NIH for fiscal year 1987 is sufficient to fund at least 6100 new and competing research grants, and to increase the number of research trainees to the level recommended by the National Academy of Sciences.

We need your help also and your support to ensure that ADAMHA is also funded to a level of $465,000,000, to allow an expanded number of new and competing grants and increased numbers of research trainees.

Secretary Bowen has told your subcommittee that NIH is getting "the most information for the money."

Let me give an example of how disastrous the loss of 1,000 research grants would be. Nearly everyone recognizes the names of Crick and Watson, who broke the genetic code, and thereby launched the era of molecular biotechnology.

Very few people, however, know the names of the many, many hundreds of scientists who made the essential, but unheralded discoveries that paved the way for Crick and Watson's breakthrough.

Those countless scientists were the base of the pyramid structure that is the essence of biological research. I urge you, Mr. Chairman, not to let the Administration or OMB pull out the 1,000 research stones from the 1987 pyramid, and the future.

Those 1,000 grants are not only the stuff of breakthroughs at the top of the pyramid, but each one of the 1,000 is also likely to be the spawning ground for one or two graduate students; in other words, the next generation of biological scientists.

The consequence is that if we lose 1,000 grants in 1987, there will be far more than 1,000 fewer scientists working for the benefit of the American people in 1991.

Mr. Chairman, the United States is the world leader in biomedical research, and we reached that position from the day when NIH had award rates of 50 to 60 percent.

Today, the grants funded represent an award rate of perhaps 25 to 30 percent. If we allow the number of new and competing grants to slide backwards, we will not only deprive the Nation of future health benefits, but we will also be losing one of the remaining bastions of world leadership, that is in biomedical research.

Mr. Chairman, I thank you for the privilege of appearing before you today.

Mr. NATCHER. Thank you very much, Dr. Riker. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Dr. Riker follows:]

STATEMENT OF WILLIAM K. RIKER

PRESIDENT

AMERICAN SOCIETY FOR PHARMACOLOGY AND
EXPERIMENTAL THERAPEUTICS

before the

HOUSE APPROPRIATIONS SUBCOMMITTEE
ON
LABOR-HHS-EDUCATION AND RELATED AGENCIES

on the

FY 1987 BUDGET

for the

NATIONAL INSTITUTES OF HEALTH
and
ALCOHOL, DRUG ABUSE AND MENTAL HEALTH
ADMINISTRATION

APRIL 28, 1986

Mr. Chairman, members of the subcommittee, thank you for this opportunity to appear before you today to discuss funding for biological and biomedical research. I am William Riker. By training I am a physician and am Professor and Chairman of the Department of Pharmacology, School of Medicine, The Oregon Health Sciences University. I am also President of the American Society for Pharmacology and Experimental Therapeutics (ASPET), and it is in this capacity that I appear before you today.

ASPET is one of the seven constituent societies of the Federation of American Societies for Experimental Biology (FASEB), which represents 28,000 scientific researchers in the biological and biomedical sciences. ASPET's purpose is to promote pharmacological knowledge and its application and to conduct research with the ultimate goal of preventing and relieving sickness and disease. We are working scientists. For that reason, the appropriations bill that funds the National Institutes of Health and the Alcohol, Drug Abuse and Mental Health Administration is of primary importance to us. We are deeply disappointed by the President's fiscal 1987 request for these agencies.

You, Mr. Chairman, and this subcommittee have been exemplary in your support of basic biological research and we appreciate this commitment. We only hope these efforts can continue in the face of the Gramm-Rudman-Hollings mandate to balance the federal budget by 1991. As I am sure you are aware, Gramm-Rudman-Hollings could have a devastating impact on relatively unprotected basic research funding if it is implemented in fiscal 1987. Congress must recognize, since the

Administration clearly does not, that basic biological research has a legitimate claim to a reasonable portion of scarce fiscal 1987 federal dollars. Basic research is a unique and humanitarian effort, undertaken for the benefit of all Americans, and, it can be argued, of all mankind. It is heavily dependent on federal support because its primary objective is disease treatment and cure and a fuller understanding of the complex processes of life, not profit. However, when viewed as an investment, it pays enormous cost-saving and life-saving dividends over the long-term. American scientists have been able to achieve international stature in the area of biological and biomedical research because of a long-term commitment by the federal government, articulated and insisted upon most powerfully by Congress and particularly by this subcommittee.

In fiscal 1987, however, the Administration would provide only $4.9 billion for NIH, a decrease of more than $400 million from the fiscal 1986 appropriation. Under this plan, NIH would support only 5,104 new and competing grants, down from 6,100 in fiscal 1986. The number of research centers would drop from the fiscal 1986 level of 550 to 523 and the number of trainees supported would fall from 9,947 to 9,250. For Alcohol, Drug Abuse and Mental Health Administration research, the Administration is requesting $318.9 million, a five percent decrease below the fiscal 1986 research funding level of $335.6 million. Investigator-initiated new and competing grants would drop from 505 in fiscal 1986 to 448 in fiscal 1987. ADAMHA training programs would be cut back from the $41 million fiscal 1986 enacted level to only $18.5 million in fiscal 1987.

These proposed cuts are deeply disturbing. The consequences of reduced funding levels for NIH and ADAMHA in fiscal 1987 cannot be summarized in terms of fewer projects supported and fewer people trained. The cost of research forgone now cannot be measured by the number of dollars saved and put toward a smaller deficit. The consequences must be weighed in terms of human suffering not alleviated and the incalculable long-term costs of lost scientific opportunity.

The progress of scientific knowledge and the momentum of discoveries also depends on our ability to recruit and train the next generation of scientists. The Administration budgets for NIH and ADAMHA tell our bright, inquisitive undergraduate and graduate students, our young, promising scientists and our established investigators that a career in federally-sponsored basic biological research may be unreasonably precarious. This instability not only drives trained researchers from the field but, more worrisomely, discourages promising young people from entering it. This loss of people cannot be easily recouped.

We note a recent National Science Foundation survey which shows that federally-funded research grants have become an increasingly important mechanism for supporting the training of pre-doctoral researchers. You should be aware of this connection between the research grant line item and the research training line item--the two complement one another and are dependent on one another for success.

We join with FASEB and the Ad Hoc Group for Medical Research Funding, a coalition of more than 150 organizations, in recommending a fiscal 1987 funding level for NIH of $6.079 billion. This funding level represents an increase of about $86 million or 1.4 percent over a current services budget. Our recommendation would restore the cuts made by the Administration budget request in a number of areas, including biomedical research support grants, and would continue most NIH programs at their fiscal 1986 level of operation. In addition, the Ad Hoc Group proposal would provide funds sufficient to raise the number of research trainees to the level recommended by the National Academy of Sciences, to upgrade and renovate primate centers and other facilities, to strengthen support for clinical trials through general clinical research centers and increase the number of specialized and comprehensive research centers.

For NIH competing and non-competing research project grants, the Ad Hoc Group recommends a current services dollar level for full funding at study section recommended amounts--a total of between $3.4 billion and $3.6 billion. This level should be sufficient to fund 6,100 new and competing NIH grants in fiscal 1987. ASPET believes Congress acted wisely in increasing the number of new and competing grants to 6,100 in fiscal 1986 and recommends that at least the 6,100-grant level be maintained in the coming fiscal year and that this number be cited by the subcommittee.

The investigator-initiated research project grant continues to be the keystone of the NIH and ADAMHA efforts because it explores questions at the cutting edge of research, offering the greatest hope for progress against disease. The number of new and competing grants and the depth of training support are key indicators of the health of these research programs. If Congress fails to make the grant and training levels a clear priority, OMB has shown it will not hesitate to reduce NIH and ADAMHA support in defiance of non-binding congressional intent, a serious setback for research.

For the Alcohol, Drug Abuse and Mental Health Administration we join with the Ad Hoc Group in recommending a research funding level of $465 million. This proposal is consistent with the Institute of Medicine recommendation that ADAMHA's research budget be doubled from 1986 to 1991. This increase would allow for an expanded level of new and competing grants, growth in Research Centers and Research Scientist Development Awards with a focus on young investigators, an increased number of trainees, and badly needed renovation of facilities and equipment.

We urge this subcommittee to provide funding levels for NIH and ADAMHA that allow us to maintain the momentum of biological, biomedical and behavioral research. As working scientists, we assure you that your support, particularly in the areas of the individual investigator-initiated research grant and training, is not only essential to our work, but the reason we have been so successful in our endeavors.

I would be happy to answer any questions you may have.

MONDAY, APRIL 28, 1986.

NATIONAL INSTITUTES OF HEALTH

WITNESS

DR. JAY H. STEIN, PRESIDENT ASSOCIATION OF PROFESSORS OF MEDICINE

Mr. NATCHER. Our next witness is Dr. Jay H. Stein. Dr. Stein, we will be pleased to hear from you at this time.

Dr. STEIN. Thank you very much.

I am speaking today as the Chairman of the Department of Medicine at the University of Texas Health Science Center at San Antonio and in my capacity as the President of the Association of Professors of Medicine, the organization that represents the chairpersons of the Departments of Internal Medicine in the Nation's medical schools.

I appreciate this opportunity to share the Association's views regarding fiscal year 1987 funding for the National Institutes of Health. Funding for the NIH is of great importance to the members of our Association because we are physician scientists and because faculty in our departments receive approximately half of the NIH grants made each year to clinical departments in U.S. medical schools.

On behalf of the 10,000 full-time faculty in departments of medicine, the Association wishes to express appreciation to the chairman and members of this subcommittee for your unrelenting efforts to assure adequate Federal funding for our national biomedical research endeavor.

Your strong support for the research agencies of the Public Health Service is particularly important in light of surveys indicating that the overwhelming majority of Americans favor increased funding for basic research and for medical science in particular.

In addition, the research community is gratified by the fact that the Congress has recognized the enormous potential of recent biomedical discoveries and has insisted upon funding levels that better enable us to pursue the exciting bioscientific leads that are being identified on an almost daily basis.

Certainly, all of us recognize that the Federal budget deficit must be reduced if we are to enjoy economic stability. Consequently, I will not presume to suggest that Federal spending for research and development should be increased.

Rather, our Association appeals to the members of this subcommittee to assure that health research receives an appropriate share of overall R&D expenditures.

It is apparent that the Administration believes the government can afford to strengthen its research programs. Under the President's budget, total Federal R&D spending would increase by approximately 16 percent.

In fact, the research programs of the Department of Defense would receive an $8,300,000,000 increase, 25 percent above the current year's spending.

Particularly when compared to budgetary growth of this magnitude, the Administration's proposal to reduce funding for the National Institutes of Health seems to us somewhat of a national disgrace. We are appalled by the Administration's research priorities as exemplified by budgetary proposals to:

Reduce funding for research on the deadly disease AIDS while proposing 70 percent growth in the "Star Wars" research budget.

Reduce by almost 1,000 the number of NIH competitive grants awarded for the study of disorders such as heart disease, arthritis and Alzheimer's disease, while proposing an increase of almost $2,400,000,000, or 60 percent in DOD advance technology development programs.

Rescind $9,000,000 from the NIH research development program for small and minority schools while proposing the initiation of a $43,000,000 DOD/NASA transatmospheric research and technology program.

Phase out the NIH facilities construction program while proposing a $453,000,000 budget for defense R&D facilities, a 16-percent increase over the current year.

I would like to emphasize that the Association fully recognizes that an adequately funded military research program is essential to our national security interests. However, the President's request for defense R&D is more than eight times the amount proposed for the NIH.

We do not believe that the importance or promise of weapons research is eight times greater than the potential benefits of today's biomedical research effort.

We respectfully suggest that if the Administration is intent upon such disproportionate growth in the military R&D budget, if should identify sources of additional revenue to cover the increased costs rather than draining the budgets of other research agencies.

Against this background, the Association believes that NIH budgetary growth can continue without impinging upon deficit reduction efforts. Specifically, we support the recommendation of the Ad Hoc Group for Medical Research Funding to increase the NIH budget to $6,069,000,000 in fiscal year 1987.

This 10 percent increase over the fiscal year 1986 appropriation would allow stable support for investigator-initiated awards at study section-recommended levels: Modest growth in research center funding as well as training and career development support; and additional funding to upgrade and renovate deteriorating animal care facilities and outmoded research laboratories.

In addition, it will provide the funding necessary for the establishment and operation of the new Institute and the Nursing Research Center recently established by the Congress. We believe that this is a responsible proposal which recognizes the funding requirements of a productive bioscience effort within the context of the need to control government spending.

In closing, Mr. Chairman, may I again express the Association's appreciation to the members of this subcommittee of your efforts on behalf of medical research. As supporters of the PHS research agencies, you have acted to protect the most important element of our national security, the public health.

We hope that you will again prevail in resisting the Administration's proposal to shortchange our Nation's bioscientific effort. I would be happy to answer any questions.

I appreciate the opportunity to be able to testify before you, sir.

Mr. NATCHER. Thank you, Dr. Stein. You have made an excellent statement. We appreciate your appearance before the committee.

MONDAY, APRIL 28, 1986.

NATIVE AMERICAN PROGRAMS

WITNESS

A. DAVID LESTER, EXECUTIVE DIRECTOR, COUNCIL OF ENERGY RESOURCE TRIBES

Mr. NATCHER. Our next witness is Mr. A. David Lester, and we will be pleased to hear from you at this time.

Mr. LESTER. Thank you, Mr. Chairman.

I am David Lester, Executive Director of the Council of Energy Resource Tribes. We are an organization of 42 tribes that represent over 50 percent of the American Indian population, and a little over 60 percent of the Indian lands in the United States.

These lands possess significant quantities of natural and energy resources. Our mission is to assist these 42 tribes improve their systems of self-government and to help them develop stable, diversified local economies.

I would like to also point out that these 42 tribes are experiencing a population increase of about 3 to 4 percent annually.

We find the ANA, Administration for Native Americans' mission of self-sufficiency to be compatible with the local goals of the member tribes. The objectives of supporting tribal social, economic development through local Native American institutions is precisely the program that we need in assisting ourselves to become self-sufficient through the development of our natural resources and our energy resources.

The President's Commission on Reservation Economies reported to President Reagan that the Administration for Native Americans is an outstanding Federal assistance program, and has developed an exemplary program framework for local development.

It noted that one of the major constraints in assisting local development is the paucity of expert assistance available to Native American tribes and other Native American communities to implement their own projects and priorities.

Our own data clearly shows a lasting beneficial development occurs when there is local control, management planning, organizing and implementation of development projects which insures not only the development of local jobs, and the necessary technology transfer to assist the community to the development process.

We specifically want to call your attention to the Training and Technical Assistance Funds in the budget which the Administration proposed to eliminate.

We believe this reduction or elimination of funding for training and technical assistance will greatly constrain the ability of Native American communities, and particularly the 42 Indian tribes that I represent today, in their goal of developing local economies.

We believe that the resultant loss of economic opportunity greatly affects gains from the reductions.

While many programs and many assistance projects were funded at increasing levels over the last two decades, the ANA budget remained relatively constant.

In 1981, the Administration for Native Americans budget was reduced by over 20 percent while overall assistance to Indian tribes was reduced by over 33 percent. We understand the imperative to control Federal spending, but we believe that we need to emphasize the positive aspects of local development that would replace the need for Federal assistance, rather than pushing the reservation population into other forms of public assistance.

We appreciate the opportunity to call this to your attention, and the opportunity to provide this testimony before your committee, Mr. Natcher.

Mr. NATCHER. Thank you very much, Mr. Lester. It has been a pleasure having you, and you made a good statement.

[The statement of Mr. Lester follows:]

TESTIMONY OF THE COUNCIL OF ENERGY RESOURCE TRIBES

BEFORE THE

HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HHS, DOE

AND RELATED AGENCIES

REGARDING THE

ADMINISTRATION FOR NATIVE AMERICANS

APRIL 28, 1986

TESTIMONY OF THE COUNCIL OF ENERGY RESOURCE TRIBES BEFORE THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HHS, DOE AND RELATED AGENCIES

Mr. Chairman, distinguished Committee members, my name is A. David Lester, Executive Director of the Council of Energy Resource Tribes (CERT). Our member tribes thank you for this opportunity to address your Committee regarding the Administration's FY 1987 budget and programs of the Administration for Native Americans.

The Council of Energy Resource Tribes is a multitribal organization of 42 tribes who collectively represent nearly half of all American Indians living on or near reservations and account for some 51,000 square miles of tribal lands; about 60% of all reservation lands in the country. These lands contain 700 million barrels and 5,000 billion cubic feet of proven oil and gas reserves, respectively, which represents approximately 7% of total national on-shore reserves. The tribes also own 30 billion tons of recoverable coal which is about one-third of the recoverable coal in the west; and tribal lands contain half of the nation's privately owned uranium reserves. Additionally, they possess significant hydroelectric and geothermal potential along with substantial quantities of shale oil and tar sands deposits.

This acreage sustains 10,000 full-time jobs and produces 364,000 barrels of oil, equivalent daily in oil, gas and coal, thereby contributing to the nation's balances of trade by displacing that amount in imports.

CERT has marked a decade of progress in which it has served as a catalyst for dramatic changes in the federal-tribal relationship, particularly those relationships that relate to mineral resource development and management.

As most of you know, the concept of CERT crystallized in 1975 when 25 Indian energy resource owning tribes signed an organizing charter. The following year, CERT was incorporated in Washington, D.C., and began working with the federal Department of Energy (DOE) (then known as the Federal Energy Administration) to include Indian tribal issues in the formulation of a balanced national energy supply. Later, under an interagency agreement which included the Department of the Interior, Department of Commerce, and Health and Human Services, the DOE began to play the added role of administrator of most federal funds directed toward assisting tribes develop their resources according to their own plans and timetables.

However, it must be remembered that resource ownership does not necessarily equate with financial wealth. Tribal resource development has been slower than that on non-Indian lands in the United States. And the financial resources needed for services to tribal members and capital for tribal development far exceed revenues from energy production. Per capita personal income for CERT member tribes is less than half of the U.S. national average of $11,000 for all citizens, and unemployment among CERT member tribes is 33% compared to 31% for all Indian tribes and four times greater than for all Americans.

The Council of Energy Resource Tribes has been in existence now for a period of ten years. For the last decade, our tribes and our organization have forged an unparalleled period of cooperation with the Congress and with the Executive Branch in much of the nation's landmark energy and environmental policies and legislation. This has been made possible in large part by the assistance we have received from ANA.

It is with grave concern, that CERT brings to the attention of this Committee that the continuing role of our tribes in the development of energy history and our continuing success in reducing our over-all need for federal support could be in fact be discontinued or limited to such an extent that the on-going work of our tribes through our professional services staff will become impossible.

We are speaking in regard to the Administration's plan for the Administration for Native Americans in the Department of Health and Human Services for Fiscal Year 1987. The Administration has once again decided to eliminate the Training and Technical Assistance funds in the ANA program budget. It is from the Training and Technical Assistance funds which CERT has received from ANA that has made it possible for us to accomplish exactly the kind of things that the President desired when he issued his 1983 Indian Policy statement. The President said in part, "Federal support will be made available to tribes to assist them in developing the necessary management capability and in attracting private capital."

For many years, the Administration for Native Americans, alone among the federal agencies serving Indian tribes, has carried out its program function in the spirit and direction prescribed by the President in his Indian policy statement.

This situation was brought to light in a report by the Presidential Commission on Indian Reservation Economies which President Reagan established in 1983 to identify for him the major obstacles hindering economic development on Indian lands.

When the Presidential Commission reported back to the President, one of its findings included very positive information about the work being coordinated by the Administration for Native Americans. ANA was singled out as an agency which had "introduced an imaginative concept in its Social and Economic Development (SEDS) approach to funding, insofar as it sought to effect cooperation on the local level, focusing on economic development synergy and outcomes."

The report further noted, however, that ANA's SEDS program was not in all cases accomplishing its objectives of creating an independent business sector on Indian reservations. Among the constraints listed by the Commission in the development of reservation economies were precisely the issues which are addressed by the Training and Technical Assistance funds which ANA administers.

The small amount of Training and Technical Assistance support which the Council of Energy Resource Tribes has received from ANA, together with like support from other federal agencies and funds raised from the private sector, has made it possible for our tribes to maintain a small core staff of dedicated professionals with expertise in geology, geophysics, drafting, accounting, economics, business management, and the environmental sciences. Each of our tribes needs all of these disciplines, but none could afford them all.

The Training and Technical Assistance funds which we have received from ANA have made it possible for us to do exactly those things which the President's Commission recommended. The benefits which our tribes have derived from these efforts far outweigh the limited resources which any one source contributes. These funds have made it possible for us to achieve precisely that economic development synergy which the President's Commission encouraged.

Congress has also monitored and been most supportive of how ANA utilizes its Training and Technical Assistance funds.

When the Administration moved to strike Training and Technical Assistance from ANA's budget last year, it was Congress who reinserted the appropriation.

While we expressed gratitude for Congress' action at that time, we feel we should emphasize our gratitude again because not too long afterward the Administration made another attempt to delete this program through the process of rescission. Once again, Congress evaluated the results of rescission against the concrete benefits generated by the program and concluded that it could not in good conscience allow this program to be rescinded.

We are here today to express our appreciation for the programs of the Administration for Native Americans, and to urge the Committee once again to retain the category of Training and Technical Assistance funds of the budget for ANA, since this category allows us to leverage the other programs made possible by the agency, and to achieve considerable economies by providing, from a common pool of talent, uncommon expertise to all our member tribes.

MONDAY, APRIL 28, 1986.

LOW INCOME ENERGY ASSISTANCE

WITNESSES

ASHLEY BROWN, COMMISSIONER, OHIO PUBLIC UTILITIES COMMISSION

PHYLLIS LEVINE, NATIONAL ASSOCIATION OF REGULATORY UTILITY COMMISSIONERS

Mr. NATCHER. Our next witness is Mr. Ashley Brown and Ms. Phyllis Levine.

Come forward, Mr. Brown and Ms. Levine. We will be pleased to hear from both of you.

Mr. BROWN. Thank you. We appreciate the opportunity to be here today.

My name is Ashley Brown and I am a Commissioner with the Ohio Public Utilities Commission. I am testifying today on behalf of the National Association of Regulatory Utility Commissioners, commonly referred to as the NARUC. With me today is Phyllis B. Levine, NARUC Assistant Director of Congressional Relations.

Since many NARUC members regulate the utilities and protect the consumers who are effected by the Low Income Home Energy Act of 1981, commonly referred to as LIHEAP, the NARUC is vitally concerned with the future of this program and greatly appreciates the opportunity to present our views at this hearing. My comments will be limited to appropriations for fiscal year 1987 for the LIHEAP program, and I will be brief.

The LIHEAP program is targeted towards relieving the burden of high utility bills of low income persons including the elderly and handicapped. Funding for LIHEAP has consistently fallen short of the program's need and we strongly urge the subcommittee to appropriate $2.5 billion to ensure sufficient funding to keep the program viable.

While LIHEAP funds do aid the poor with subsidies for their utility bills, more effort is needed to permanently reduce the need for the subsidy by increasing conservation efforts, such as weatherization of dwellings. Two recent studies in Ohio indicate that the levels of consumption by the poor, were higher than that of other customers, is directly related to poor weatherization in their dwellings. While the energy crisis might be taking a respite, inefficient consumption will lead the nation right back to the times of gasoline lines, oil rationing, and excessive prices.

Today, just as in 1980, the only thing certain about the energy future is that it is uncertain and will be full of surprises. LIHEAP should be furthering the national policy of conserving energy. In order to accomplish that goal while responding to local conditions, state and local authorities should be given greater discretion in deciding the mix between paying bills and conservation measures, as they are the ones who deal directly with the problem.

NARUC applauds LIHEAP for assuring that the neediest households receive preference in the distribution of assistance and is grateful for the 100 percent federal funding, but NARUC feels that the Administration's recommended freeze at $2.1 billion is not enough to assure assistance for all those who need it. The 1986 appropriations of $2.1 billion has already been reduced due to the cuts authorized by the Gramm-Rudman Deficit Reduction Act, and therefore, some needy families are not getting their fair share. Moreover, the energy burden of other consumers will be increased in order to make up revenue inadequacies.

The NARUC strongly opposes any efforts to reduce congressional appropriations for the program because of money available from the overcharge fund. This money should be used to compensate the consumers who overpaid and not for deficit reduction purposes. Moreover, there is no guarantee that the states will use this money for LIHEAP, as they have discretion to use it for a variety of programs. In fact, the Administration has, unfortunately, recommended no funding for the Department of Energy's very successful weatherization assistance program because of the availability of oil overcharge funds. Should that shortsighted recommendation be followed, it is likely that the states will apply their portion of the overcharge monies to continue to fund their weatherization programs and not use it for LIHEAP or the other programs designated by law.

In conclusion, the NARUC respectfully urges the subcommittee to appropriate $2.5 billion to carry out the Low Income Home Energy Assistance Act of 1981. While that amount will still be insufficient to meet the need, NARUC believes it is a reasonable compromise between needs and the financial restraints required to reduce the budget deficit.

NARUC further urges the subcommittee to consider long term goals of energy conservation and require a greater percentage of the appropriation to be used for conservation purposes rather than bill subsidies. A dollar spent on weatherization today will reduce the need for subsidies in the future.

Thank you for your attention.

Mr. NATCHER. Well, Mr. Brown, thank you very much for appearing before the committee. You have made an excellent statement.

Ms. Levine, it has been a pleasure having you.

Dr. LEGERTON. Thank you.

[The testimony of NARUC follows:]

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION AND RELATED AGENCIES

TESTIMONY OF
NATIONAL ASSOCIATION OF REGULATORY UTILITY COMMISSIONERS

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ON

FISCAL YEAR 1987 APPROPRIATIONS FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

APRIL 28, 1986

Summary of Testimony on the Appropriations of Funds for the Low-Income Home Energy Assistance Program

* The National Association of Regulatory Utility Commissioners (NARUC) strongly supports the appropriation of sufficient funding for the Low-Income Home Energy Assistance Program (LIHEAP).

* As authorized by 42 U.S.C. Sec. 8621, the Secretary of Health and Human Services is authorized to make grants to States to assist eligible households to meet the costs of home energy.

* A greater percentage of the funding should be used for energy conservation measures rather than restitution for energy bills resulting form over-consumption.

* The NARUC strongly opposes the use of monies from the oil overcharge fund to supplant congressional appropriations for LIHEAP.

* The NARUC seeks the assistance of the Subcommittee in aiding low-income families by appropriating $2.5 billion for energy assistance and conservation.

Mr. Chairman and Distinguished Members of the Subcommittee:

Introduction

My name is Ashley Brown and I am a commissioner with the Ohio Public Utilities Commission. I am testifying today on behalf of the National Association of Regulatory Utility Commissioners, commonly referred to as the "NARUC". Accompanying me today is Karen Lee Hochstein, NARUC Director of Congressional Relations and Phyllis B. Levine, NARUC Assistant Director of Congressional Relations.

The NARUC is a quasi-governmental nonprofit organization founded in 1889. Within our membership are the governmental agencies of the fifty States and the District of Columbia, Puerto Rico and the Virgin Islands engaged in the regulation of utilities and carriers. Our chief objective is to serve the public interest by seeking to improve the quality and effectiveness of government regulation.

The members of the NARUC greatly appreciate your invitation to address the Subcommittee on the Fiscal Year 1987 Appropriations for the U.S. Department of Health and Human Services. The NARUC is particularly interested in securing sufficient funding for the Low-Income Home Energy Assistance Act of 1981, (LIHEAP), 42 U.S.C. 8621-29, sections 2601-2611, commonly referred to as Title XXVI, since many of our members regulate the utilities who are affected by this legislation. This program is administered by the Department of Health and Human Services, and is targeted towards relieving the burden of high utility bills of low-income persons including the elderly and handicapped. Once the LIHEAP funds are distributed among 50 States, there is so little available per state that the the States usually are compelled to use 100% of the LIHEAP funding to pay utility bills rather than pursuing conservation measures such as weatherization. In fact, the recipients receive on average only enough to cover about 45 percent of their heating bills. Funding in LIHEAP has consistently fallen short of the program's need and we strongly support sufficient funding to ensure its continued viability.

Subsidies: Conservation vs. Energy Bills

As State Commissioners who regulate retail electric and natural gas rates, our members are continuously aware of the burden that increasing fuel costs impose on the consumers. We are especially mindful of the hardships these increases work on the poor and elderly. Escalating energy prices affect those least able to handle such increases: the poor and persons living on low fixed incomes. In addition, these people face the problem of spiraling summer electric bills as they try to cool their households. Extreme heat can pose as serious a threat as extreme-cold.

To further exacerbate the problem of rising gas and electricity costs, there has been an overall reduction in the Nation's public assistance benefits. The poor and elderly find themselves with less income assistance and higher utility bills. As a result, they become delinquent in their payments. Their delayed payments may mean that other utility ratepayers must carry the increased burden imposed on a utility's cost of service. This makes the problem of adequate energy assistance for low income households of concern to everyone.

Delinquent payments often lead to disconnection by the utility companies of a customer's service. The following is an example of the number of disconnects by two companies who serve approximately the same number of customers, derived from a combined analysis of three NARUC surveys: Southern Connecticut Gas Company of Bridgeport, Connecticut, which serves the fifth most expensive service territory in the nation disconnected 8,674 of its gas customers in 1984, while Southern Indiana Gas and Electric Company of Evansville, Indiana, the 22nd least expensive territory, disconnected 4,372 of its gas customers in 1984.[1] While there are various reasons why a residential customer does not pay his utility bill, for many low-income citizens it is simply that they were forced to make a choice for their family between "heating and eating."

Energy complacency stalks our nation. There appears to be an attitude that the energy problem is conquered. Indicators frequently relied on as proof include downward movement in world oil prices and the current oversupply of oil stocks.

Another view, however, would indicate we are not out of the woods yet. Hostilities in the Middle East threaten oil supplies. Electricity rates increase as coal transportation costs increase due to the nation's inability to construct efficient transportation systems for coal and the current regulatory policies of the Interstate Commerce Commission regarding coal shipped by rail. All of these factors present a discomforting picture which seem to demand the implementation of policies which address the fundamental element of the problem, high usage of energy.

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[1] NARUC Survey of Residential Gas Bills, Winter 1984-85, October 1, 1985; NARUC Survey of Electric and Natural Gas Utility Uncollectible Accounts and Service Disconnections for 1984, October 3, 1985.

The Use of Low-Income Home Energy Assistance Funds to Weatherize Dwellings of Low-Income Individuals

It is frustrating to have to point out that energy welfare too often leads to energy waste. State and local governments are not the only champions of waste through underpriced utility services. The Federal government started funds flowing for energy aid to the poor, but only to pay bills, that is, to subsidize overconsumption by low-income households. Only recently have funds been made available for use on conservation measures and then only fifteen percent. 42 U.S.C. Sec. 8625(k).

It is inappropriate for utilities to get on this track after the energy is consumed. Although the poor benefit by reactive measures, such as bill check-off systems where consumers can add an amount to their bills to help pay emergency bills for the poor, it would be more beneficial to use the funds to initially conserve energy. Next year's bills will be no lower than this year's, but they could be lowered by a comprehensive joint Federal-State program.

The use of LIHEAP funds for conservation measures needs to be sharply increased, especially in light of the administration's request that no funds be appropriated for the Department of

Energy's Weatherization Assistance Program. In fact, the mix between paying bills and putting in conservation measures should be decided at local option. Let those dealing directly with the problem employ their best strategy. This means State and local authorities should have greater discretion as to how much of their LIHEAP allotment should be used for conservation and for subsidizing payment of utility bills.

Strengths of the Low-Income Home Energy Assistance Block Grant and Program Areas that Need Further Development

In general, the most positive aspects of the Act are that it provides for:

1. One hundred percent (100%) Federal funding;
2. Flexibility for States to reserve funds for crisis intervention;
3. The coordination of LIHEAP activities with similar and related programs;
4. Assurances that the neediest households receive preference in the distribution of assistance;
5. Equal treatment for renters and homeowners and for persons in view of other criteria; and
6. Flexibility for States to hold up to twenty-five percent (25%) of their allotment for the current fiscal year for use in the following fiscal year.

Some areas needing further development or attention include provisions for:

1. Use of LIHEAP funds for weatherization and energy-related home repairs; and

2. Increased funding levels.

The law might be bolstered with provisions which show some sensitivity to the needs of moderate to middle-income households.

It is important to address the fundamental problem of high usage of energy. Low-income households tend to need weatherization or conservation measures most. However, as demonstrated by current program limitations, eighty-five percent (85%) or more of most states' assistance funds are used to pay energy bills, largely subsidizing over-consumption. Additional funding should be made available to be used for conservation measures. Conservation benefits the consumer, energy suppliers and the country as a whole.

The amount of funds authorized for LIHEAP remained constant at $ 2.1 billion for FY 1985 and FY 1986, but appropriations were subsequently reduced by Gramm-Rudman budget cuts. In FY 1987 the Administration is recommending a freeze at $ 2.1 billion. There are no provisions made for the effects of inflation; consequently, in real terms less money was made available to serve the same amount of people in the last three years of the program. Most reasonable forecasts predict higher energy costs for the near term. This means that without additional funding even more people will go without assistance.

Funding LIHEAP from the Petroleum Overcharge Restitution Fund

The NARUC opposes any attempt of supplanting congressional appropriations for LIHEAP with funds from the judgment in United States v. Exxon Corp., 773 F. 2d 1240 (TECA 1985), cert. denied, 54 U.S.L.W. 3499 (U.S. 1-28-86). Under this judgment, $2.1

billion will go to the States for distribution under one or more of five designated programs, one of which is the LIHEAP.

Oil overcharge funds should be applied in a way that remedies past injuries and not simply used to supplant congressional appropriations to fund ongoing Federal programs. In addition, since States have discretion over distribution of the money, there is no guarantee to low-income households that they will ever benefit from these funds. If the Oil Overcharge Fund is to be used as a funding source, then it should be used to supplement rather than supplant congressional appropriations.

CONCLUSION

There is a growing need to lower energy usage and the most efficient way to accomplish this is to use a greater percentage of LIHEAP funds for conservation measures. It is the position of NARUC that funds should be used to prevent energy waste rather than subsidizing energy bills of low-income households that result from over-consumption. NARUC also strongly opposes the funding of LIHEAP from the Petroleum Overcharge Restitution Fund.

The NARUC respectfully requests that $2.5 billion be appropriated for the LIHEAP program and that a greater portion of that appropriation be used for conservation measures.

Thank you for this opportunity to present our views.

TUESDAY, APRIL 29, 1986.

NATIONAL INSTITUTE OF DIABETES, DIGESTIVE AND KIDNEY DISEASES

WITNESSES

DR. JOHN T. FARRAR, PRESIDENT, COALITION OF DIGESTIVE DISEASE ORGANIZATIONS

DR. C.W. LEGERTON, CHAIRMAN, COMMITTEE ON PUBLIC POLICY AND GOVERNMENTAL RELATIONS, AMERICAN GASTROENTEROLOGICAL ASSOCIATION

DR. DONALD O'KIEFFE, CHAIRMAN, LEGISLATIVE COMMITTEE, THE AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY

DR. ALVIN GELB, BOARD MEMBER, AMERICAN COLLEGE OF GASTROENTEROLOGY

DR. WILLIAM SILEN, DIRECTOR, DIGESTIVE DISEASE RESEARCH CENTERS

DR. DONALD E. WILSON, CHAIRMAN, NATIONAL DIGESTIVE DISEASES ADVISORY BOARD

BETTIE JEAN HOWARD, PRESIDENT, SOCIETY OF GASTROINTESTINAL ASSISTANCE

TRACY CIRELLA, LIVER TRANSPLANT RECIPIENT, AMERICAN LIVER FOUNDATION

Mr. NATCHER. Now, the following eight witnesses, if you will please come up and have a seat at the table.

Dr. Farrar and Dr. Legerton, Dr. O'Kieffe, Dr. Silen, Dr. Gelb, Dr. Wilson, Ms. Betty Jean Howard and Tracy Cirella. We are delighted to have you all before the committee and we will be pleased to hear from you.

Dr. Farrar, you will be the spokesman and you can introduce the others.

I am John T. Farrar, a physician, President of the Digestive National Coalition. I am also a Professor of Medicine at the Medical College of Virginia and a former President of the American Gastroenterological Association. I appreciate very much the opportunity to appear before you. I represent 20 voluntary and professional organizations, with a total membership of more than 110,000 members. These constituent organizations have joined together in this coalition for the purpose of improving the quality of care of patients with digestive diseases and those who lack adequate nutrition. In this testimony, when I use the term digestive diseases, I implicitly include disturbances in nutrition as we consider assuring good nutrition an intrinsic part of our task.

Appearing with me on this panel are representatives of six of the constituent organizations of our coalition. You will hear testimony about many of the different needs of the digestive disease community. On one thing we all agree. We need support for the various programs at the National Institutes of Health to continue to make progress in our campaign against the ravages of digestive diseases.

We strongly support the figure of $400,000,000 for the NIDDK and $6.3 billion for the entire NIH. These figures are supported by the Ad Hoc Coalition on Biomedical Research.

Mr. NATCHER. What is the figure you used for NIH?

Dr. FARRAR. The NIDDK or NIH?

Mr. **Natcher**. NIH.

Dr. **Farrar**. Six point three billion dollars.

Mr. **Natcher**. Thank you very much. Go right ahead.

Dr. **Farrar**. This is a very crucial year. The President's proposed fiscal year 1987 budget risks dismantling the finest medical research establishment the world has ever known or conceived of. The National Institutes of Health has surpassed the expectations of almost all of us in the last 25 years and these institutes have achieved unprecedented success in research and research training in all medical fields. To do something to jeopardize this superb enterprise suggests a lack of understanding of the necessity for stability and continuity in the scientific community.

Let me be specific about two programs—research training and the Digestive Diseases Clearinghouse.

The training of physicians and PHDs for research careers in the fight against digestive diseases is seriously jeopardized by the President's budget. If the NIDDK is unable to support young scientists as they embark on a career in gastroenterological research, they will give up academic medicine, go into practice and their research talents will forever be lost to this country. We do not get a second chance at their genius.

At the present time there are 15 superb applicants for career awards currently being considered by the Division of Digestive Disease and Nutrition of the NIDDK. Under current constraints, only three can be funded and no research career development awards can be funded. Next year it could be worse. Two million dollars alloted specifically to digestive disease training will enable the NIDDK to keep our best young scientists in academic medicine working on digestive disease problems.

The second program of the NIDDK which urgently needs support is the NDDEIC, the Digestive Disease Clearinghouse. I served as the Chairman of the Long Range Planning Committee for this unit and now serve as the Chairman of the Executive Committee of the Clearinghouse Advisors. This modest but very important program provides education to patients on how to obtain medical care, how to prevent disease and how to cope with disease. These patient education programs are preventative, relatively inexpensive, and enlist many community agencies in a team effort to prevent, cure and modify diseases of the digestive track.

Mr. Chairman, please allow me to thank you and the rest of the subcommittee for your courageous efforts, in this time of fiscal stringency, to adequately maintain support for all health programs. We deeply appreciate your support and commend your wisdom.

[The statement of Dr. Farrar follows:]

**Digestive
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National
Coalition**

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Founder & President Emeritus
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United Ostomy Association

TESTIMONY OF

JOHN T. FARRAR, M.D.
PRESIDENT OF
THE DIGESTIVE DISEASE NATIONAL COALITION

BEFORE THE

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, EDUCATION AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES

CONCERNING

FUNDING FOR DIGESTIVE DISEASE PROGRAMS
FOR FISCAL YEAR 1987

ON

APRIL 28, 1986

Digestive
Disease
National
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Pennsylvania Society of Gastroenterology
Society for Gastrointestinal Assistants
The Society for Surgery of the Alimentary Tract
United Ostomy Association

Funding Recommendations for Fiscal Year 1987
DIGESTIVE DISEASE NATIONAL COALITION

A. National Institute of Diabetes, Digestive and Kidney Disease: $499 million. This level of funding would provide a modest growth rate for the institute and provide for the stabilization of the centers programs at the institute.

B. Digestive Disease Division: $150 million of the institutes funding for the Digestive Disease Division of NIDDK. This level would represent a degree of parity among the institute priorities.

C. Digestive Disease Centers Program: $11.2 million. This level of funding would allow the NIDDK to continue the meritorious centers research grants currently being funded and fund two additional centers to study pancreatic disorders and pediatric GI diseases.

D. Clinical Nutrition Research Units: $4.2 million - maintain adequate support for Clinical Nutrition Research Units and add one more.

E. DD Advisory Board: $350,000. The outstanding efforts of the DD Advisory Board should be funded at a rate very similar to other advisory boards.

F. Epidemiology and Data System: $4.5 million. To support the substantial effort being conducted to establish liver transplant data, endoscopy data, and basic digestive data and information.

G. National Digestive Disease Education and Information Clearinghouse: $500,000. To support the current outstanding efforts to provide education and information to thousands of patients, family members and professionals concerned with diseases of the digestive system.

H. Specific Funding for Training of Research Specialists: $2 million. Allocated specifically to enable the NIDDK to keep our best scientists in academic medicine working on digestive disease problems. The DD division has 15 meritorious applicants, and under current constraints only 3 can be funded and no Research Career Development Awards can be funded.

I am John T. Farrar, a physician, President of the Digestive Disease National Coalition. I am also a Professor of Medicine at the Medical College of Virginia and a former President of the American Gastroenterological Association. I appreciate very much the opportunity to appear before you. I represent 20 voluntary and professional organizations, with a total membership of more than 45,000 members. These constituent organizations have joined together in this Coalition for the purpose of improving the quality of care of patients with digestive diseases and those who lack adequate nutrition. In this testimony, when I use the term digestive diseases, I implicitly include disturbances in nutrition as we consider good nutrition an intrinsic part of our task.

The interest of our 20 organizations are many and you will hear individually from the representatives of five our member organizations. We are of one mind, we need support for the various Digestive Disease programs at the National Institutes of Health to continue to make the progress necessary in our fight against digestive diseases.

This is a very crucial year. The President's proposed FY'87 budget risks dismantling the finest medical research establishment the world has ever known or conceived of. The National Institutes of Health has surpassed the expectations of almost all of us in the last 25 years and these institutes have achieved unprecedented success in research and research training in all medical fields. To do something to jeopardize this superb enterprise suggests a lack of understanding of the necessity for stability and continuity in the scientific community.

Let me be specific about digestive disease:

The training of physicians and Ph.D.'s for research careers in the fight against digestive diseases is seriously jeopardized by the President's budget. If the NIDDK is unable to support young scientists as they embark on a career in gastroenterological research, they will give up academic medicine, go into practice and their research talents will forever be lost to this country. We do not get a second chance at their genius.

At the present time there are 15 superb applicants for career awards currently being considered by the Division of Digestive Disease and Nutrition of the NIDDK. Under current constraints, only 3 can be funded and no Research Career Development Awards can be funded. Next year it could be worse. $2.0 million allotted specifically to Digestive Disease training will enable the NIDDK to keep our best young scientists in academic medicine working on digestive disease problems.

Another very great need is for funds to establish the National Digestive Diseases Data System. The National Commission on Digestive Diseases, in 1979, recommended the establishment of such a system for the purpose of ascertaining the national epidemiological pattern of digestive diseases. If we are to recognize the contribution of genetic, environmental, emotional and dietary factors in the causation of digestive diseases, we must determine the frequency of various diseases in various segments of the population, the rural, the aged, infants and children, industrial workers, people under stress, and the obese. We urgently need data. This was recognized by the Congress in 1985 when they authorized the Director of the NIADDK to establish the National Digestive Diseases Data system for the collection, storage, analysis, retrieval and dissemination of data derived from a patient population with digestive diseases, including where possible, data involving general populations for the purpose of detection of individuals with a risk of developing digestive diseases (PL99-158). Unfortunately no specific funds were appropriated for this purpose. A starting budget of $4.8 million is strongly urged for FY'87.

An additional program I would like to endorse and advocate is the Digestive Disease Research Centers. Dr. William Silen, one of the Directors of a Center will testify later. I simply want to tell you that these are centers of intellectual excellence and they will pay handsome dividends for the health of our country and we commend you for your support of these centers. One of the officers of the Coalition recently said "Today's research is tomorrows medicine". It is certainly true. We are talking about future health, not esoterica.

A final program of the NIDDK which urgently needs support is the NDDEIC, the Digestive Disease Clearinghouse. I served as the Chairman of the Long Range Planning Committee for this unit and now serve as the Chairman of the Executive Committee of the Clearinghouse Advisors. This modest but very important program provides education to patients on how to obtain medical care, how to prevent disease and how to cope with disease. These patient education programs are preventative, relatively inexpensive, and enlist many community agencies in the teamwork to prevent, cure or modify disease of the digestive tract.

My last comment will be to urge you to do your best to maintain all critical service programs that are geared toward patient care and treatment. This includes Medicare, Medicaid and various block and categorical programs funded by your subcommittee. Mr. Chairman, please allow me to thank you and the rest of the subcommittee for your courageous efforts, in this time of fiscal stringency, to adequately maintain support for all health programs, We appreciate your support.

I am pleased to respond to any questions you may have.

Dr. **Farrar**. I am pleased to respond to any questions you may have.

Mr. **Natcher**. Thank you very much, Doctor. You have made an excellent statement. We appreciate your appearance.

Dr. **Farrar**. Thank you.

Now I would like to ask Dr. Clarence Legerton to continue the testimony from our panel.

Dr. **Legerton**. Mr. Chairman, I am Clarence W. Legerton, M.D., Professor of Medicine at the Medical University of South Carolina.

It is my privilege to represent and to speak for the American Gastroenterological Association, which has over 5000 physician members vitally concerned with the improvement of patient care and research in the field of digestive diseases.

Mr. Chairman, we are very aware of the support you and this committee have given to research in our field, and we appreciate this support very much. Unfortunately, there has been a serious decline in overall research dollars available to the National Institute of Diabetes, Digestive and Kidney Diseases. This obviously translates into decreased dollars available for the digestive diseases and nutrition component of this institute.

In 1985 the figure was $91,238,000.

In FY 1986 the figure fell to $85,789,000.

While in 1987 it is slated to be $83,328,000.

Of course, Mr. Chairman, we recognize that under the committee's leadership the Congress rejected the proposed rescission, so that in fact the total dollars for FY 1986 will be slightly higher than I have just indicated. Even with the restored funds, the FY 86 budget still will be seriously below the FY 85 budget. So we urge you to reject the Administration budget out of hand as it would reduce research in our field by almost 19 percent.

The major issue which we think is of crisis proportions is that of research manpower. Since 1986 the total of all NIH trainees in digestive disease manpower has been dropping steadily. This trend has been exacerbated this year by cuts required by Gramm-Rudman-Hollings. Simply put, if we do not have a continuous influx of highly motivated and intelligent young people into our field, we can expect with certainty to have a significant decreased in the progress we have made in recent years in digestive disease research.

Research careers within the Division of Digestive Diseases and Nutrition are fostered in three ways: clinical investigator research awards, individual physician scientist awards, and research career development awards. The total number of these awards has been dropping steadily. In 1984 there were 40 such awards; in 1985, 37, and the estimate for 1986 is 26. You have heard Dr. Farrar say that while there are 15 highly qualified candidates, only three can be funded.

Accordingly, the primary recommendation of the American Gastroenterological Association is that funding be increased for the career development of physicians and basic scientists, to enable ten new awards in digestive diseases, and five new awards in nutrition each year.

Second, we urge you to increase support of research training, as recommended by the National Academy of Sciences, through the National Research Award mechanism.

Our other major interest is in the digestive diseases research centers. The Congress, through your help, Mr. Chairman, has been extraordinarily supportive of digestive disease centers. There are now 12 such centers. These centers produce unique opportunities for collaborative research by basic and clinical scientists in established centers of excellence. Yet the proposed funding cuts will seriously impair research efforts within these centers. In 1987, if the proposed Administration budget for the NIDDK takes effect, the budget for each center will be reduced by 20 percent.

With cuts of such magnitude research efforts within these centers cannot help but be seriously impaired, technical personnel will be lost, and the output of research by teams of investigators will certainly decline.

So we urge the Congress to restore center budgets to full budget amounts as recommended by study sections and to provide a small amount of funds to initiate planning grants for the development of a limited number of comprehensive digestive diseases centers in the future. Two fruitful areas, presently not covered are research in pancreatic diseases and in pediatric digestive diseases.

In closing, Mr. Chairman, we add our support to Dr. Farrar's comments regarding needed funding for the Digestive Diseases data system and the Clearinghouse. Thank you for the opportunity to appear before you again this year. Your support is vital to us and is deeply appreciated.

Mr. NATCHER. Thank you, Doctor.

We want to thank you for your appearance. You have made an excellent statement.

[The statement of Dr. Legerton follows:]

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TESTIMONY
OF THE
AMERICAN GASTROENTEROLOGICAL ASSOCIATION

Presented by

Clarence W. Legerton, M.D.

Chairman, Public Policy and
Government Relations Committee

Before the

HOUSE SUBCOMMITTEE ON LABOR-HHS APPROPRIATIONS

APRIL 28, 1986

AGA POSTGRADUATE COURSE
MAY 17, 18, 1986
SAN FRANCISCO HILTON & TOWERS

ANNUAL MEETING
MAY 18-21, 1986
MOSCONE CONVENTION CENTER

HEADQUARTERS HOTEL
SAN FRANCISCO HILTON & TOWERS

OFFICIAL PUBLICATION: GASTROENTEROLOGY

Mr. Chairman, I am Clarence W. Legerton, M.D., Professor of Medicine at the Medical University of South Carolina at Charleston.

I represent the American Gastroenterological Association which has over 4,000 physician members concerned with the improvement of patient care and research in the field of digestive diseases.

Mr. Chairman, this Committee has long been supportive of the research in the field of digestive diseases, and once again we thank you deeply for that.

We understand that at hearings earlier this year, when the Administration witnesses and the National Institutes of Health officials presented, the level of frustration of the Members of this Committee with the proposed Administration budget mirrored our own frustration.

You will see at the end of this testimony a chart which indicates the serious decline in research dollars available to the National Institute of Diabetes, and Digestive and Kidney Diseases overall (less the amounts for the new Arthritis, Musculoskeletal and Skin Institute), as well as the decreased dollars available for the Digestive Diseases and Nutrition component of this institute.

If you will look at that bottom line you will note that the figures for digestive diseases research in fiscal year 1985, fiscal year 1986 after the sequestrations of the Gramm-Rudman-Hollings Act, and the proposed rescissions, and other administrative adjustments, and the proposed fiscal year 1987 Administration budget, all show a precipitous decline for research in this field. The comparable figures are:

FY 1985 - $91,238,000

FY 1986 - $85,789,000

FY 1987 - $83,328,000

Of course, Mr. Chairman, we recognize that under this Committee's leadership the Congress rejected the proposed rescission, so that in fact the total dollars for fiscal year 1986 will be slightly higher than those indicated.

Nevertheless, even with those amounts restored, the fiscal year 1986 budget will be seriously below the fiscal year 1985 budget.

We urge you to reject the Administration's proposed budget out of hand, as it would result in a decrease of nearly 9% below the fiscal year 1985 levels. If you add in an inflation factor of at least 5% per year (the biomedical research deflator), you will find that if the Administration's budget proposal for fiscal year 1987 would be agreed to, there would in fact be a loss of nearly 19% of research done in this field.

It is unfortunate that the Administration proposes these decreases at a time when the field of digestive diseases and nutrition research is burgeoning, especially because of the strong support given by this Committee in recent years to the digestive diseases research centers.

It is not necessary to go into detail here about the various research advances that have been occurring, as it is our understanding that this Committee held comprehensive hearings on that matter and have received information from the Institute about advances now being made.

Because of the shortness of time available to us, Mr. Chairman, resulting from the pressures that you are under given the new budgetary scheduling requirements, rather than dwell on the rapid advances that are being made in our field, I would prefer to talk about the structures that support some of these areas of investigation.

RESEARCH MANPOWER

Mr. Chairman, many of my colleagues believe we face a real, not imagined, crisis in research manpower in digestive diseases research.

Our studies show that since 1968, the total of all NIH trainees in digestive diseases research has been dropping steadily. This trend, in combination with the confusion that has existed for more than a decade in the public policy debate over research funding, and the further exacerbation caused this year by the cuts required by Gramm-Rudman-Hollings, causes us very serious concern about the future research enterprise in digestive diseases.

Simply put, without a continuous influx of highly motivated and intelligent young people into our field, we can expect with certainty slower research progress than would otherwise be possible.

I would like to describe the background of the situation, indicate the specific issues which concern us, and make recommendations to this Committee to deal with them.

Background

Research career development: there are 3 types of career development award mechanisms used by the Division of Digestive Diseases and Nutrition (DDDN) in the support of the digestive diseases research community. Two of these, the Clinical Investigator Research Award (CIA) and the Individual Physician Scientist Award (PSA) are key to providing adequate opportunity for M.D.'s to acquire sufficient research training and experience to become qualified as independent investigators. The third mechanism, the Research Career Development Award, is of particular importance in the support of both Ph.D.'s and M.D.'s working in the areas of basic science that are the underpinning of studies on digestive diseases research training following medical and early research training and up to the time in the physician's career when research support through the traditional NIH research project grant becomes reasonable. The RCDA enables the young established investigator, who is otherwise burdened with non-research academic duties, to be dedicated entirely to research during a very crucial stage of career development.

Research training: the National Research Service Award (NRSA) provides individual postdoctoral fellowship support and research trainee positions through institutional training grants. This stage of training support is vital to the continued availability of well-trained researchers in digestive diseases. Notably, it provides a training link between an M.D.'s clinical training and the stage where that person can qualify for a CIA. NRSA support is essential to maintaining a pool of physicians both qualified and motivated to staff the Nation's medical schools.

Issues

The research career award budget has become so restricted that we anticipate a very severe decline in capacity to support career award candidates in digestive diseases. There are 15 applicants for career awards currently being considered by the Division of Digestive Diseases and Nutrition (DDDN) for support who have priority scores of 155 or better: viz., 2 for RCDA's, 4 for PSA's and 9 for CIA's. Of these 15 applicants, DDDN can plan to fund, under current constraints, 3 PSA's (see Table 1). The number of NRSA awards funded in digestive diseases has remained relatively constant (see Table 2); however, the Institute of Medicine in its 1985 report 'Personnel Needs and Training for Biomedical and Behavioral Research' urges an increase in NRSA support to meet projected needs of academic medicine.

Table 1. Numbers of research career awards in digestive diseases, Fiscal Years 1982-1985 and 1986 estimate. (K04 = Research Career Development Award, K08 - Clinical Investigator Award, K11 = Physician Scientist Award).

	Mechanism			
Fiscal Year	K04	K08	K11	(Total)
1982	21	12	N.A.	33
1983	17	18	N.A.	35
1984	19	21	0	40
1985	15	21	1	37
1986 (est)	12	11	3	26

Table 2. Digestive diseases National Research Service Awards, individual postdoctoral fellowships and estimates of trainee slots on institutional training grants, Fiscal Years 1982-1986.

	Fiscal Year				
Mechanism	1982	1983	1984	1985	1986
Trainees on Institutional Training Grants	106	114	118	121	110
Postdoctoral Fellowships	22	33	30	29	29

Recommendations

1. Increase funding for the career development of M.D.'s and in selected basic science areas, for Ph.D.'s, to enable 10 new awards in digestive diseases, and 5 new awards in nutrition each year.
2. Increase support of research training, as recommended by the National Academy of Science, through the National Research Service Award mechanism.

CENTERS

Mr. Chairman, the Congress has been extraordinarily supportive of digestive diseases centers. Since fiscal year 1984, when this Committee provided funding for six new digestive diseases research centers (there were two established previously), with an additional four established in fiscal year 1985, there are now 12 digestive diseases centers funded by the NIDDK. Attached to this testimony is a map which shows with black circles where these digestive diseases research centers are located. In fiscal year 1985, all the center grants in the NIDDK, including the digestive diseases center grants, received a reduction of 6% of the amount recommended by the peer review study sections. Then, in fiscal year 1986 the center grants will have to accept a budget reduction of 13% because of the sequestrations (though this might be modified slightly becuase the Congress has not agreed to the proposed rescissions). However, in fiscal year 1987, if the proposed Administration budget for the NIDDK takes effect, the budget for each center will be reduced by 20%.

The attached chart shows what the budget levels look like for fiscal year 1985 through fiscal year 1987, and I have included on the right hand side a level proposed for the Digestive Diseases Centers and the five Clinical Nutrition Research Units supported by this institute. You will note that the full funding of these centers, a total of $9.688 million would be required for the 12 Digestive Diseases Centers and $3.556 million for the Clinical Nutrition Research Units.

We believe that the situation could not be more starkly drawn than in these charts. If these proposed budget reductions for centers take place, the research efforts within these centers will be seriously impaired, and especially the newly established collaborative efforts will be hampered. We know that technical personnel are going to be lost and that the level of research efforts by teams of investigators are certain to decline.

RECOMMENDATION: CENTERS

We urge the Congress:

(1) to provide funds to restore center budgets to full budget amounts as recommended by study sections, if necessary inserting bill report language to bolster whatever line item figures are put into the bill; and

(2) to provide a small amount of funds to initiate planning grants for the development of a limited number of comprehensive digestive diseases centers in the future (We believe that planning on these centers, even though funds might not be available for several years, should go forward.).

We believe that there are two areas especially fruitful for research by such digestive diseases centers which presently are not covered; these include (1) pancreatic disorders and (2) pediatric digestive diseases research.

DIGESTIVE DISEASES DATA SYSTEM

Mr. Chairman, let me move to a second area of significant concern for us, and that is the national Digestive Diseases Data System.

As long ago as 1979, the National Commission on Digestive Diseases recommended to the Congress the establishment of a Digestive Diseases Data System to determine the national epidemiological pattern of digestive diseases.

Although this recommendation was made nearly seven years ago, there have never been funds to develop such a program, which is so vital in order that we can begin to draw a comprehensive plan of attack on digestive diseases.

Bill report language provided by this Committee in 1985 authorized the Director of the NIADDK to establish such a data system. That language has been repeated in your bill reports ever since. Additionally, the recently passed authorization legislation for the NIH (P.L. 99-158) lays out specific authorization for such a data system.

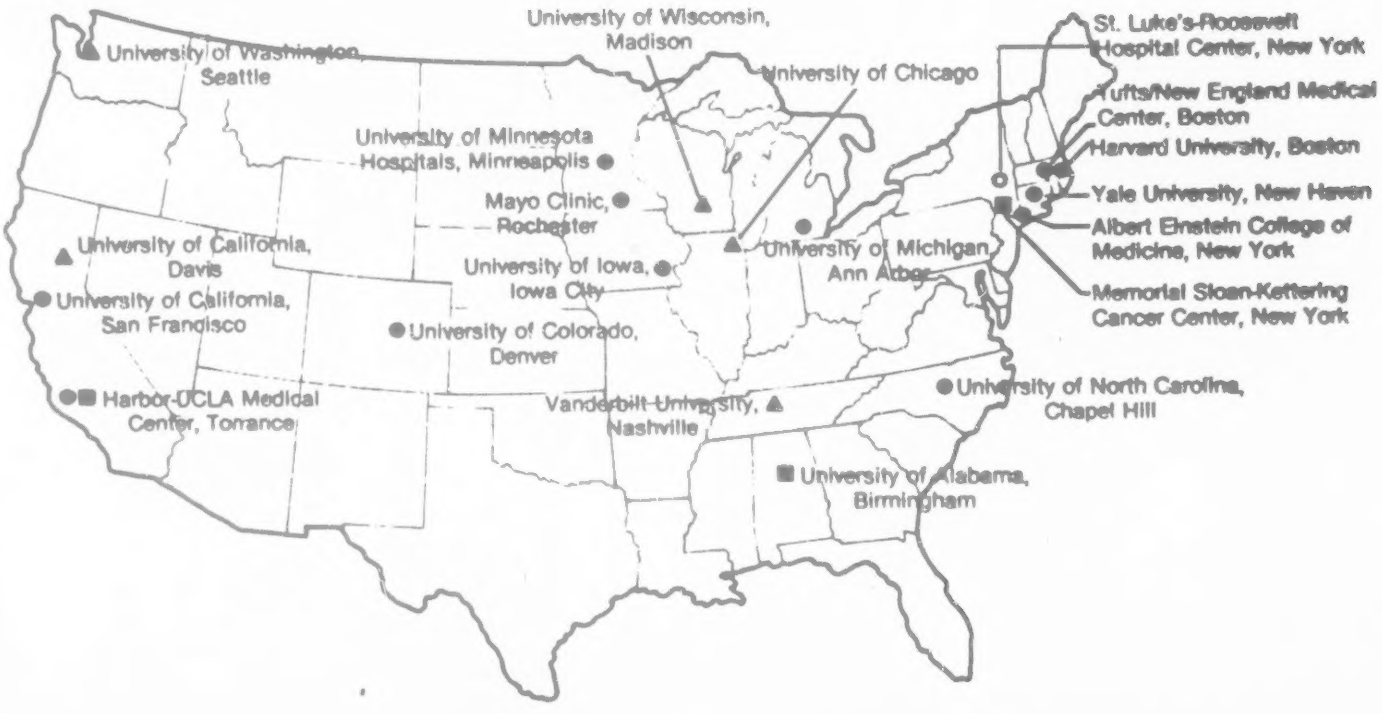
RECOMMENDATION: DATA SYSTEM

We recommend that this Committee provide funds to establish the national Digestive Diseases Data System. It is estimated that a budget of $4.5 million should be added to provide for this system.

SUMMARY

Mr. Chairman, we thank you for allowing us to appear before you again this year. We would be pleased to answer any qeustions you have, and once again we wish to express our deep appreciation to you for all of the support that you have given to biomedical research over the years, but especially that in the area of digestive diseases and nutrition.

Centers Program of the Division of Digestive Diseases and Nutrition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Vanderbilt University, Nashville
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● Digestive Disease Research Center ▲ CNRU (NIADDK funded) ■ CNRU (NCI funded) ○ Obesity Research Center

NATIONAL INSTITUTE OF DIABETES, AND DIGESTIVE AND KIDNEY DISEASES*

Appropriations History

FY 1985, 1986, and Proposed 1987

*FY 1985 and 1986 continue inclusion on top line of Arthritis, Musculosksletal and Skin Programs, but FY 1987 with those deducted.

	1985	Revised 1986	Proposed Budget 1987
APPROPRIATION	$ 543,576,000	$ 569,597,000	$ 418,971,000
Administrative Reduction		-257,000	
Sequester (Gramm-Rudman-Hollings)		-24,482,000	
Rescission		-7,980,000	
	543,576,000	536,878,000	418,971,000
Transfer to New AMS Institute	-108,808,000	-109,788,000	--
Add and Subtract Various Administrative Adjustments			
Total Comparable Appropriations** NIDDK	427,968,000	429,687,000	418,971,000
Total Comparable Appropriations** Digestive Diseases and Nutrition	91,238,000	85,789,000	83,328,000

**Figures after all sequesters, rescissions and adminsitrative adjustments.

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FACT SHEET

This fact sheet accompanies testimony given to the U.S. Senate and U.S. House of Representatives subcommittees on Labor-HHS-Education appropriations, during April, 1986.

The American Gastroenterological Association recommends:

1. That a major emphasis of this year's appropriations process be on digestive diseases research manpower.

   It is becoming increasingly clear that an increase in funding for the career development of MD's and in selected basic science areas for PhD's is vital to the continued influx of researchers into our field. Additionally, increased support for research training, as recommended by the National Academy of Science, is also needed

   There are 3 types of career development awards mechanisms; two of these, the Clinical Investigator Research Award and the Individual Physician Award are key to providing adequate opportunity for MD's to acquire sufficient research training and experience to become qualified as independent investigators. The third mechanism, the Research Career Development Award, is of particular importance in the support of both Phd's and MD's working in the areas of basic science that are the underpinning of studies on digestive diseases.

   Also the National Research Service Award provides individual postdoctoral fellowship support and research training through institutional training grants.

2. We support funding of the Digestive Diseases centers at levels proposed by peer review study sections; the centers have in the past several years been cut below these levels, and if the Gramm-Rudman-Hollings cuts take place once again in FY 1987, it is probable that some of these centers will curtail activities in research significantly.

3. We support funding of the National Digestive Diseases Data System, which has been provided by appropriations bill language for several years, and last year by authorization in the biomedical research authorization legislation--it has, however, never been funded, and is vital to understanding the epidemiological pattern of digestive diseases in our nation.

4. We support the NIDDK coalition call for funding levels of $504 million for the institute in FY 1987, and support the Ad Hoc Coalition for Biomedical Research proposed levels of $6.07 billion, for all of NIH for FY 1987.

OFFICIAL PUBLICATION: GASTROENTEROLOGY

Dr. **Farrar**. We next have Dr. Donald O'Keiffe.

Mr. **Natcher**. We will be delighted to hear from you.

Dr. **O'Kieffe**. This is the fourth year I have had the opportunity and privilege to appear before this committee. Personally, and on behalf of the ASGE I would like to thank this committee and its chairman for the strong support it has given biomedical research over the past few years. The digestive disease community is particularly grateful for the level of funding for NIH and the specific bill language for digestive diseases, especially for the centers program.

The message has been heard—that message which has been given by countless individuals to this and other congressional committees—namely that medical advances which we, as a society, enjoy today had their roots five or ten years ago. Likewise, the level of health care given to American citizens five or ten years from now will be affected by today's decisions—including some of the budgetary issues in front of this committee today.

We are fully aware of the constraints on this committee by the need to reduce the federal deficit. I can only urge that during the budget proposals that the various organizations presenting today agree on be given strong consideration during your deliberations.

The specific proposals have already been mentioned, including funding for the digestive disease centers programmed the data system. They are listed in my prepared testimony which I would like to submit for the record.

For the past several years I have brought either endoscopic instruments or special catheters to demonstrate to you in a hand on first hand way some of the advances within the endoscopy world and discuss with you the beneficial spinoff of these advances for the American public.

This year I was a little hesitant to challenge the imagination of the security people at the front door. Their skeptical looks last year when they scrutinized these devices made me think twice about bringing them back this year.

What I would like to do for the last few minutes is briefly discuss one subject which I think exemplifies the potential marriage between primary research, fiberoptics and the prevention of a serious health problem in the United States. I am referring to cancer of the colon.

This subject, which has been a very important health issue in the United States has achieved increased visibility and attention since the President's illness. Accounting for 135,000 new cases of cancer a year and 65,000 deaths, it is the second leading malignancy in our society. However, what we now know and understand about cancer of the colon allows us to at least imagine a day when cancer of the colon might be eliminated.

We feel that almost all colon malignancies begin in previously benign colon polyps. With the use of fiberoptic instruments, we can detect and remove colon polyps without hospitalization or surgery, thus interrupting the sequence leading to cancer.

All we need to do is discover, hopefully economically, those patients with polyps or a strong predisposition to polyps. This is where NIH and NIH grants enter the picture. Researchers at various institutions, including at the National Institutes of Health, are working on blood and stool tests which could be economically administered on a mass screening basis to detect those individuals who should be studied further and have their colons carefully looked at for polyps.

At the same time, important research into possible dietary and genetic factors responsible for polyp genesis is going on.

Thus, with the newer concepts of the natural history of colon cancer coupled with clearer understanding of the epidemiology of this illness, we are poised to launch a frontal attack on the problem. If monocloral antibodies or some other laboratory technique becomes available to detect the population at risk, the fiberoptic technology already exists to do rest. Realistically we should be able to greatly reduce the incidence of this second most common cancer of our society.

Much of the credit for where we are today can be traced to legislation and funding of preceding congresses. We, who represent the GI community today, hope that strong funding and bill report language will continue to be forthcoming.

Mr. NATCHER. You made an excellent statement. We appreciate your appearance.

[The statement of Dr. O'Kieffe follows:]

A/S/G/E the AMERICAN SOCIETY for GASTROINTESTINAL ENDOSCOPY

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TESTIMONY

OF THE

AMERICAN SOCIETY FOR GASTROINTESTINAL ENDOSCOPY

Presented by

DONALD O'KIEFFE, M.D.

CHAIRMAN, LEGISLATIVE COMMITTEE

before the

HOUSE SUBCOMMITTEE ON LABOR-HHS-EDUCATION APPROPRIATIONS

APRIL 28, 1986

Mr. Chairman, I am Donald O'Kieffe, a practicing gastroenterologist in the District of Columbia and a faculty member of George Washington University Medical Center.

I represent the American Society of Gastrointestinal Endoscopy, an organization of more than 3,000 gastroenterologists and surgeons who specialize in the diagnosis and treatment of diseases of the digestive tract.

I thank you for the opportunity to testify before you today about the opportunities in research regarding the general field of endoscopy, but also the difficulties the field of digestive diseases research is having as a result of budget reductions, both already accomplished, and proposed.

If one can gauge the future by recent years, certainly the field of endoscopy and the research enterprises it can and will assist show remarkable promise.

I would like to take a few moments to describe recent advances in endoscopy, and would like afterward to make several budgetary recommendations.

Gastrointestinal Endoscopy

Endoscopes use light-transmitting technology to illuminate internal organs and tissues in the body; the illuminated image is then sent back to the viewer through optical lenses or bundles of optical fibers. Fiberoptic endoscopy, for example, enables the physician to make a specific diagnosis of a gastrointestinal disease, often when xrays are not specific or normal. Specific sites of upper gastrointestinal bleeding can be identified. Polyps, the precursors of colon cancer, can be diagnosed and removed by this modality. The bile and pancreatic ducts are now accessible to these instruments and gallstones can be extracted without surgery. All of these endoscopic innovations have resulted in less surgery, shortened hospital stays and reduced time lost from work--not to mention reduced suffering and cost savings.

A new accessory for flexible endoscopes, a toposcopic catheter developed by NIH intramural scientists in the Biomedical Engineering and Instrumentation

Branch (BEIB) is now undergoing clinical trials. It is used in conjunction with a drainage catheter that can be passed through the endoscope to drain fluids from the biliary and pancreatic ducts, and is extremely useful in patients with malignant obstructions. A three-way collaborative program between NIDDK, BEIB, and the Uniformed Health Services Medical School in Bethesda continues with results to be presented at the AGA meeting in San Francisco next month.

Another new adaptation, an endoscopic ultrasound imaging device, allows a physician to observe the full thickness of the intestinal wall, of importance in the diagnosis of Crohn's disease, a chronic disorder that involves the entire thickness of the bowel wall. This new device may well be useful in planning therapy for tumors of the stomach, esophagus, or colon.

Video technology in the field of endoscopy is moving forward rapidly. By connecting a recorder to a miniature endoscopic camera, a physician can obtain a high-resolution video image of the gastrointestinal tract and play back all or a portion of the recording for detailed analysis without involving the patient in additional examinations, and serves as an excellent record of the patient's stage of disease.

Lasers and other electrosurgical devices for use in endoscopy are improving rapidly, and not only allow endoscopic hemostasis of bleeding lesions, but also permits in many cases the destruction of cancers in patients who would not have been treated with surgery. However, one long-term need for the development of laser and fiberoptic technology is far afield from the laboratories of the National Institutes of Health and the academic and industrial scientists it supports. The need is in space. As the committee is probably aware, there is tremendous potential for the development of unique manufacturing systems and processes in a zero gravity environment. There are two elements of the zero gravity environment which could have a significant impact on fiberoptic technology. One of these is the ability to create homogeneous mixtures. On the earth's surface gravity tends to influence the heavier components of a mixture so that there may be an uneven distribution when the mixture solidifies. This state of non-homogeneity influences the efficiency of these solidified compositions altering electrical properties and longevity. A second area deals with the process of heating solid materials to form mixtures which then solidify after they cool. Whenever one performs this heating process on earth it must be performed in a crucible or vessel which can withstand the applied heat. Invariably, small amounts of the wall of the crucible dissolve and enter the molten material. This process introduces small amounts of impurities into the final product again reducing efficiency. Therefore, the society supports the concept of increased research in space on those manufacturing processes which can improve materials' purity and homogeneity.

As you can see, the use of the endoscope and its allied technologies can facilitate earlier and more accurate diagnosis and appropriate therapies, help avoid unnecessary surgical interventions, and also when used to remove colon polyps and common bile duct stones clearly reduces hospitalization time, the need for surgery, and the economic impact on the patient and insurance systems. Increasingly, these improvements are proving to be beneficial to research programs, as they extend the fact-finding opportunities in such projects.

Appropriations for FY 1987 for Digestive Diseases Research

We would like to express our concerns, along with our colleagues in the field of digestive diseases research and the patient advocacy groups, about the serious problems which now exist in digestive diseases research funding.

First, we would like to indicate that the first year of Gramm-Rudman-Hollings, decreasing all program entities by 4.3%, in fact has reduced the fiscal year 1986 appropriations level to that of fiscal year 1985. This has caused serious problems in the funding of research grants, as well as serious problems for the continuous development of research manpower for the area of digestive diseases. You have heard many times of the negative effect caused by year by year variations in funding for the young people in our research fields, which cause them to be more and more uncertain about the opportunities for future careers.

Also, we are concerned about the funding of the Digestive Diseases Centers. As you have learned, these centers which have represented a major forward thrust for the digestive diseases community in the research area, were under-funded last year as cutbacks were made below the peer reviewed recommended level. Our concern is that if a second year of Gramm-Rudman-Hollings cuts (sequestrations) occurs, many of these centers will have to reduce their work force and research materials so significantly that any progress will be seriously hampered.

We are concerned about funding for the national Digestive Diseases Data System. As you know, Mr. Chairman, this data program has been mentioned in the past three years by appropriations bill reports, and we express our appreciation to you for that. However, it should also be understood that this program has never been funded despite your concerns. Additionally, last year in the Biomedical Research Amendments of 1986, the legislation which eventually passed, carried complete authorization for the Digestive Diseases Data System. Now that both authorization and appropriations committees have agreed to its need, we hope that you will see to its funding.

Also, Mr. Chairman, we support a level of $504 million for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), and agree with the NIDDK Coalition on that amount for fiscal year 1987.

We also support the Ad Hoc Coalition for Biomedical Research's support of the NIH funding level of $6.07 billion for fiscal year 1987.

Summary

Mr. Chairman, the digestive diseases community has appeared before you nearly 15 years now, and it has been my privilege to appear before you three times. Each time you have been most courteous and have established an appropriations level for digestive diseases research which has allowed us to move the field forward rapidly.

We are deeply grateful to you for that and for your support of all biomedical research.

I would be pleased to answer any questions you may have.

A/S/G/E the AMERICAN SOCIETY for GASTROINTESTINAL ENDOSCOPY

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APPROPRIATIONS HEARINGS FACTS SHEET FOR FY 1987

The American Society for Gastrointestinal Endoscopy recommends the following in terms of appropriations for digestive diseases research in FY 1987.

1. The continued funding of the Digestive Diseases Advisory Board, the Information and Education Clearinghouse for Digestive Diseases, and the beginning of funding for the authorized Digestive Diseases Data System.

   The latter is of considerable importance, as it would permit us for the first time to get a sense of the epidemiology of digestive diseases in the nation--this is particularly important for the improved treatment modalities utilizing endoscopy in its various forms.

2. The funding of the Digestive Diseases Centers across the nation. A new program, vigorously supported by appropriations only in the last several years, the centers program is already beginning to show advances in the field. However, in the last several years, cuts have been made to the agreed-upon levels of funding by the peer review system, and further cuts caused by a FY 1987 sequestration order following Gramm-Rudman-Hollings would cause severe cutbacks in the work being done there.

3. Increased attention should be paid to the very remarkable advances now occurring in the field of endoscopy, in terms of the contributions that can be made to research.

   The new technologies springing up in this field can have enormous consequences for research: for example, the toposcopic catheter is now undergoing clinical trials. It can be used in conjunction with a drainage catheter that can be passed through the endoscope to drain fluids from the biliary and pancreatic ducts, and is extremely useful in patients with malignant obstructions; another adaptation, an endoscopic ultrasound imaging device, allows physicians to observe the full thickness of the intestinal wall, and will aid in diagnosis of diseases such as Crohn's disease; and the field is being enhanced by video technology, which permits high-resolution video image-making and playback.

   Only appropriate levels of funding will permit research work to go forward in these areas.

4. Support is given to the NIDDK coalition's request for $504 million for this institute for FY 1987, and for the Ad Hoc Coalition on Biomedical Research' request of $6.07 billion for FY 1987.

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Dr. FARRAR. The next speaker, Mr. Natcher, is Dr. Alvin Gelb.

Mr. NATCHER. We would be pleased to hear from you.

Dr. GELB. Mr. Chairman and members of the subcommittee, I am Dr. Alvin Gelb, Chief of the Division of Gastroenterology at the Beth Israel Medical Center in New York and a member of the National Affairs Committee of the American College of Gastroenterology. The American College of Gastroenterology has a deep commitment to clinical investigation to allow for the best possible treatment and total care of patients with gastrointestinal disease.

I would like to devote the time allotted to me to describe recent clinical advancement that has been achieved and which has a profound impact on the practice of gastroenterology. Many of the startling developments have resulted from basic research carried out at NIH, made possible through research grants provided for NIH and the research centers.

Digestive diseases are a major cause of disability due to illness in the United States. Approximately 20,000,000 Americans suffer chronic digestive problems; 14,000,000 experience acute digestive disease illness. Diseases of the gastrointestinal tract are responsible for $50 billion annually in lost work, lost wages, uncollected taxes, disability and health care payments. Approximately 200,000 deaths each year are due to digestive diseases. More Americans are hospitalized with digestive problems than any group of disorders, which include the salivary glands, esophagus, stomach, liver, gall bladder, biliary tract, pancreas, small and large intestines.

Gallstones are responsible for an estimated 25,000,000 Americans suffering from gallbladder disease which costs the American public $1,000,000,000 in surgical expenses annually. NIDDK funded researchers are able to provide explanations of new gallstones are formed, treated and prevented.

Research personnel have been investigating methods to dissolve stones that would avoid the cost and risk of major surgery. Recently an investigator working at NIDDK successfully dissolved gallstones in patients with a new nonsurgical procedure that uses a solvent called methy tertiary butyl ether. The technique performed under local anesthesia involved the placement of a catheter which is actually a very thin, flexible tube, through the abdominal wall into the gallbladder. Small amounts of MTBE were then injected through the catheter directly into the gallbladder. Within several hours the stones in each of the patients began to dissolve. If such an alternative to abdominal surgery for removing gallstones can be perfected, it may result both in enormous costs savings and in a safer substitute to surgery, especially for those patients at high risk.

Stones which most often are found in the gallbladder can also be detected in the bile ducts. Stones found in the bile ducts may have passed from the gallbladder, may have developed spontaneously in the bile duct, may have passed down from ducts which originate within the liver, and may have been discovered as residual stones following gallbladder surgery. Stones sufficiently large may obstruct the passage of bile through the biliary ductal system with sequential complications. Consequently, stones are best removed to avoid or correct the complications that have developed.

An alternative method other than surgical intervention has been introduced which will remove the stones from the bile ducts. This procedure is made possible by the use of a specially designed endoscope passed via the mouth, esophagus, stomach and duodenum to the opening of the common duct. The opening of the bile duct is enlarged and the endoscope is able to withdraw the stone. On some occasions the enlargement of the opening of the bile duct will enable the stone to pass spontaneously. Thus abdominal intervention is not required. The morbidity—the extended hospitalization—will decrease the cost appreciably. An endoscopic removal of the stone is about one third the cost of surgical intervention for the same purpose.

As a result of intensive investigation, a considerable amount of knowledge has determined the composition of stones and the constituents in bile that predispose to gallstone formation. As a result, medical therapy has been devised for dissolving the gallstones. Two medications have been particularly appropriate for this purpose. For elderly patients or patients who represent poor operative risks this form of treatment may be preferred to surgery.

Peptic ulcers have affected an estimated four million people in the United States. As a result of the greater understanding of ulcer formation new drugs have been introduced which have dramatically improved the treatment of peptic ulcers. One class of drugs known as the H2 blockers, of which cimetidine and ranitidine are exmaples, suppress acid secretion. Another known as Sucralfate coats the base of the ulcer and protects from further damage by the presence of acid.

An entirely new approach in ulcer research is the role of brain gut petides, short chains of amino acids that are found within the central nervous system and the gut. Investigators in the NIDDK have studied the effects of the brain gut peptides and found a relation to the formation of ulcers when stress is present. As a result of the greater knowledge and increased forms of treatment peptic ulcer patients requiring hospitalization for treatment of this illness has dropped over 40 percent in the past ten years.

One of the ten disabling diseases of the intestinal tract is inflammatory bowel disease, which incorporates Crohn's disease and ulcerative colitis. More than two million Americans suffer from chronic inflammatory disorder of the small and/or large bowel. IBD is a disease which is characterized by bloody diarrhea and pain. By virtue of the intensive efforts by NIDDK supported scientists, creative agents in the development of IBD have been identified. With this new discovery direction is provided for the development of therapy that is believed will counter the effects of the two substances. By continued investigative efforts the understanding and treatment of inflammatory bowel disease has made possible a reduction in the mortality due to illness. In 1960 over 3,000 Americans died from inflammatory bowel disease. The most recent figures show that the mortality is well below 800 annually.

One of the more serious types of diarrhea is found in cholera. The morality was exceedingly high until it was realized that the fatality was due to an excessive loss of fluid from the intestinal tract. Successful treatment was possible by the replacement intravenously of a large number of liters of fluid with appropriate electrolytes.

Lactase deficiency, which is characterized by an intolerance to milk and milk products can be responsible for diarrhea, bloating and severe crampy abdominal pain. By careful and persistent investigation the cause of this disorder was revealed and as a result, the defect was corrected by adding the missing enzymes into the milk before ingestion.

Another cause of diarrhea attributed to malabsorption is celiac disease which has been found to be due to an allergy to a fraction of wheat protein. Investigators have proven that by eliminating the responsible substance, the otherwise uncontrolled diarrhea can be brought under control.

Another intestinal disorder responsible for malabsorption is Whipple's disease which ultimately was attributed to an atypical bacteria which has responded successfully to the proper antibiotic treatment.

The esophagus recently has drawn a considerable amount of attention to clinical investigators who have acquired a greater knowledge of the physiology and pathology. One of the methods used in the approach to esophageal disorders is esophageal mutility studies. Achalasia, which is characterized by stricture formation at the distal end of the esophagus, formerly was dependent upon surgery for relief, has not been found to improve by careful stretching and dilatation of the lower esophageal sphincter. Cardospasm, which is a functional disorder of the lower esophagus, is not responsive to new medication therapy.

Cirrhosis is the liver disease that most commonly causes death. In addition to liver failure, one of the most dreaded complications of cirrhosis is hemorrhage from perforation of dilated veins that develop in the esophagus. Emergency treatment which as proved to be highly successful in stopping the acute bleeding episode is obtained by injection of a coagulating agent into the dilated veins with the production of a clot and subsequent control of the bleeding.

This relatively new form of treatment enables a more thorough evaluation to be carried out to determine what plans for lasting benefits might be provided. Not infrequently, the injection of a coagulating agent will prove adequate without additional treatment. One of the other complications of cirrhosis is liver failure, which is manifest by drowsiness and coma due to hepatic encephalopathy. The administration of branched chain amino acids has proven successful in ameliorating the encephalopathy.

Liver transplant has moved into a recognized form of treatment of liver diseases due to selected causes. With the better understanding of the proper case selection and the complications following liver transplantation the survival of this dramatic procedure has decreased to 80 percent.

One of the most exciting advancements in the study of colon disease has been the development of the colonoscope which permits examination of the entire colon. The significant advantage of colonoscopy is the ability to detect polyps that are not recognized by the conventional barium enema. By this method the cancerous polyps and early carcinomas have been able to be removed without necessarily resorting to the surgical resection of involved bowel. The development of expertise in the management of the colonoscope can readily be applied in providing prophylactic care in the surveillance of the large bowel carcinoma.

In another form of liver disease, severe hypercholesterolemia is the result of liver impairment to remove a type of cholesterol recognized as low density lipoprotein from circulation. Elevated levels of low density lipoprotein result in coronary artery disease and in the more severe cases, death before the age of 30. In the early stages of hypercholesterolemia due to low density lipoprotein successful management has been achieved by restricting the dietary intake of saturated fatty acids and cholesterol. NIDDK investigators have found a combination of drugs that acts to increase the uptake of the low density lipoprotein by the liver, thus decreasing its concentration in the blood and at the same time, increasing the conversion of cholesterol into bile acids, producing a 50 percent reduction in the blood LDL levels.

Mr. Chairman, these are just a few of the important advances in the understanding of the mechanism responsible for the development of diseases and new therapies that have been introduced for improvement in control and attainment of successful therapy. The intensive and persistent efforts to uncover causes of disease to allow for proper treatment has been the result of the extraordinary contributions made at NIH, made possible grants due to the funding to NIH and research centers.

In order to maintain this high degree of productivity the support by federal resources becomes of paramount importance. Restrictions imposed by the current budget proposal and the Office of Management and Budget are impeding the dedicated effort of the investigators and obstructing the attainment of desired goals. The achievements of the past should not be allowed to falter because of inefficient funding.

The American College of Gastrenterology has for many years stressed the continuing need to insure an abundant supply of clinical and basic biomedical researchers. The documentation and collection of data related to gastrointenstinal illness is paramount in the investigative community's efforts to recognize genetic, environmental, emotional, and dietary causes of digestive diseases. The recently established Digestive Disease Research Centers programs have been most productive and gratifying. Support is needed for continued success.

The American College of Gastroenterology strongly commends the accomplishments of the Digestive Disease Advisory Board, whose strategy for the prevention and ultimate treatment of digestive diseases is well recognized.

The Digestive Disease Epidemiology Data System deserves special recognition in accumulation of valuable data.

Expression of appreciation should be directed to the Digestive Disease Education and Information Clearinghouse, which has been a source of knowledge that is disseminated both to professional and lay organizations.

This concludes my testimony, Mr. Chairman. I am pleased to respond to any questions you may have.

Mr. NATCHER. Thank you very much, Dr. Gelb. You made an excellent statement. We appreciate your appearance.

[The statement of Dr. Gelb follows:]

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ON BEHALF OF

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COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES

CONCERNING

FUNDING FOR HEALTH PROGRAMS
FOR FISCAL YEAR 1987

ON

APRIL 28, 1986

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Funding Recommendations for Fiscal Year 1987
AMERICAN COLLEGE OF GASTROENTEROLOGY

A. National Institute of Diabetes, Digestive and Kidney Disease: $499 million. This level of funding would provide a modest growth rate for the institute and provide for the stabilization of the centers programs at the institute.

B. Digestive Disease Division: $150 million of the institutes funding for the Digestive Disease Division of NIDDK. This level would represent a degree of parity among the institute priorities.

C. Digestive Disease Centers Program: $11.2 million. This level of funding would allow the NIDDK to continue the meritorious centers research grants currently being funded and fund two additional centers to study pancreatic disorders and pediatric GI diseases.

D. Clinical Nutrition Research Units: $4.2 million - maintain adequate support for Clinical Nutrition Research Units and add one more.

E. DD Advisory Board: $350,000. The outstanding efforts of the DD Advisory Board should be funded at a rate very similar to other advisory boards.

F. Epidemiology and Data System: $4.5 million. To support the substantial effort being conducted to establish liver transplant data, endoscopy data, and basic digestive data and information.

G. National Digestive Disease Education and Information Clearinghouse: $500,000. To support the current outstanding efforts to provide education and information to thousands of patients, family members and professionals concerned with diseases of the digestive system.

H. Specific Funding for Training of Research Specialists: $2 million. Allocated specifically to enable the NIDDK to keep our best scientists in academic medicine working on digestive disease problems. The DD division has 15 meritorious applicants, and under current constraints only 3 can be funded and no Research Career Development Awards can be funded.

Mr. Chairman and members of the subcommittee, I am Dr. Alvin Gelb, Chief of the Division of Gastroenterology at the Beth Israel Medical Center in New York and a member of the National Affairs Committee of the American College of Gastroenterology. The American College of Gastroenterology has a deep commitment to clinical investigation to allow for the best possible treatment and total care of patients ill with gastrointestinal disease.

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Gallstones are responsible for an estimated 25 million Americans suffering from gallbladder disease which costs the American public 1.0 billion dollars in surgical expenses annually. NIDDK-funded researchers are able to provide explanations of how gallstones are formed, treated and prevented.

Research personnel have been investigating methods to dissolve stones that would avoid the cost and risk of major surgery. Recently an investigator working at NIDDK successfully dissolved gallstones in patients with a new non-surgical procedure that uses a solvent called Methyl Tertiary Butyl Ether (MTBE). The technique performed under local anesthesia involved the placement of a catheter which is actually a very thin flexible tube, through the abdominal wall into the gallbladder. Small amounts of MTBE were than injected through the catheter directly into the gallbladder. Within several hours the stones in each of the patients began to dissolve. If such an alternative to abdominal surgery for removing gallstones can be perfected, it may result both in enormous costs savings and in a safer substitute to surgery especially for those patients at high risk.

Stones which most often are found in the gallbladder can also be detected in the bile ducts. Stones found in the bile ducts may have passed from the gallbladder, may have developed spontaneously in the bile duct, may have passed down from ducts which originate within the liver, and may have been discovered as residual stones following gallbladder surgery. Stones sufficiently large may obstruct the passage of bile through the biliary ductal system with sequential complications. Consequently, stones are best removed to avoid or correct the complications that have developed. An alternative method other than surgical intervention has been introduced which will remove the stones from the bile ducts. This procedure is made possible by the use of a specially designed endoscope passed via the mouth, esophagus, stomach and duodenum to the opening of the common duct. The opening of the bile duct is enlarged and the endoscope is able to withdraw the stone. On some occasions the enlargement of the opening of the bile duct will enable the stone to pass spontaneously. Thus abdominal intervention is not required. The morbidity, the extended hospitalization will reduce the cost appreciably. An endoscopic removal of the stone is about one-third of the cost of surgical intervention for the same purpose.

As a result of intensive investigation, a considerable amount of knowledge has determined the composition of stones and the constitutents in bile that predispose to gallstone formation. As a result, medical therapy has been devised for dissolving the gallstones. Two medications have been particularly appropriate for this purpose. Chendeoxycholic acid and Ursodeoxycolic acid have proven to be effective. For elderly patients or patients who represent poor operative risks this form of treatment may be preferred to surgery.

Another approach to the management of residual stones in the common bile duct has been performed by the introduction of a catheter into the bile duct through which a substance such as Monactonoin can be instilled as an alternative method to again dissolve the stones in the ducts.

Peptic ulcers have affected an estimated 4 million people in the United States. As a result of the greater understanding of ulcer formation new drugs have been introduced which have dramatically improved the treatment of peptic ulcers. One class of drugs known as the H2 blockers, of which Cimetidine and Ranitidine are examples suppress acid secretion. Another drug known as Sucralfate coats the base of the ulcer and protects from further damage by the presence of acid. An entirely new approach in ulcer research is the role of brain-gut peptides, short chains of amino acids that are found within the central nervous system and the gut. Investigators in the NIDDK have studied the effects of the brain-gut peptides and found a relation to the formation of ulcers when stress is present. As a result of the greater knowledge and increased forms of treatment peptic ulcer patients requiring hospitalization for treatment of this illness has dropped over forty percent in the past ten years.

One of the ten disabling diseases of the intestinal tract is inflammatory bowel disease which incorporates Crohn's disease and ulcerative colitis. More than two million Americans suffer from chronic inflammatory disorder of the small and/or the large bowel. IBD is a disease which is characterized by bloody diarrhea and pain. By virture of the intensive efforts by NIDDK-supported scientists creative agents in the development of IBD have been identified. Two groups of compounds, prostaglandins and leukotrienes are manufactured in the body and play a role in mediating inflammation. With this new discovery direction is provided for the development of therapy that is believed will counter the effects of the two substances. By continued investigative efforts the understanding and treatment of inflammatory bowel disease has made possible a reduction in the mortality due to illness. In 1960 over three thousand Americans died from inflammatory bowel disease. The most recent figures show that the mortality is well below 800 annually.

One of the more serious types of diarrhea is found in cholera. The mortality was exceedingly high until it was realized that the fatality was due to an excessive loss of fluid from the intestinal tract. Successful treatment was possible by the replacement intravenously of a large number of liters of fluid with appropriate electrolytes.

Lactase deficiency which is characterized by an intolerance to milk and milk products can be responsible for diarrhea, bloating and severe crampy abdominal pain. By careful and persistent investigation the cause of this disorder was revealed and as a result the defect was corrected by adding the missing enzymes into the milk before ingestion. Another cause of diarrhea attributed to malabsorption is celiac disease which has been found to be due to an allergy to a fraction of wheat protein. Investigators have proven that by eliminating the responsible substance the otherwise uncontrolled diarreha can be brought under control. Another intestinal disorder responsible for malabsorption is Whipple's disease which ultimately was attributed to an atypical bacteria which has responded successfully to the proper antibiotic treatment.

The esophagus recently has drawn a considerable amount of attention to clincal investigators who have acquired a greater knowledge of the physiology and pathology. One of the methods used in the approach to esophageal disorders is esophageal motility studies. Achalasia which is characterized by stricture formation at the distal end of the esophagus formerly was dependent upon surgery for relief, has now been found to improve by careful stretching and dilatation of the lower esophageal sphincter. Cardiospasm which is a functional disorder of the lower esophagus is now responsive to new medication therapy.

Cirrhosis is the liver disease that most commonly causes death. In addition to liver failure one of the most dreaded complications of cirrhosis is hemorrhage from perforation of dilated veins that develop in the esophagus. Emergency treatment which as proven to be highly successful in stopping the acute bleeding episode is obtained by injection of a coagulating agent into the dilated veins with the production of a clot and subsequent control of the bleeding. This relatively new form of treatment enables a more thorough evaluation to be carried out to determine what plans for lasting benefits might be provided. Not infrequently the injection of a coagulating agent will prove adequate without additional treatment. One of the other complications of cirrhosis is liver failure which is manifest by drowsiness and coma due to hepatic encephalopathy. The administration of branched chain amino acids has proven successful in ameliorating the encephalopathy.

Liver transplant has moved into a recognized form of treatment of liver diseases due to selected causes. With the better undertanding of the proper case selection and the complications following liver transplantation the survival of this dramatic procedure has increased to 80 percent.

One of the most exciting advancements in the study of colon disease has been the development of the colonscope which permits examination of the entire colon. The significant advantage of colonoscopy is the ability to detect polyps that are not recognized by the conventional barium enema. By this method the cancerous polyps and early carcinomas have been able to be removed without necessarily resorting to the surgical resection of involved bowel. The development of expertise in the management of the colonscope can readily be applied in providing prophylactic care in the surveillance of the large bowel carcinoma.

In another form of liverdisease, severe hypercholesterolemia is the result of liver impairment to remove a type of cholesterol recognized as low density lipoprotein from circulation. Elevated levels of low density lipoprotein result in coronary artery disease and in the more severe cases, death before the age of thirty. In the early stages of hypercholesterolemia due to low density lipoprotein successful management has been achieved by restricting the dietary intake of saturated fatty acids and cholesterol. NIDDK investigators have found a combination of drugs that acts to increase the uptake of the low density lipoprotein by the liver, thus decreasing its concentration in the blood and at the same time increasing the conversion of cholesterol into bile acids, producing a fifty percent reduction in the blood LDL levels.

Mr. Chairman, these are just a few of the important advances in the understanding of the mechanism responsible for the development of diseases and new therapies that have been introduced for improvement in control and attainment of successful therapy. The intensive and persistent efforts to uncover causes of disease to allow for proper treatment has been the result of the extraordinary contributions made at NIH, made possible by grants due to the funding to NIH and research centers. In order to maintain this high degree of productivity the support by federal resources becomes of paramount importance. Restrictions imposed by the current budget proposal and the Office of Management and Budget are impeding the dedicated effort of the investigators and obstructing the attainment of desired goals. The achievements of the past should not be allowed to falter because of inefficient funding.

The American College of Gastroenterology has for many years stressed the continuing need to insure an abundant supply of clinical and basic biomedical researchers. The documentation and collection of data related to gastrointestinal illness is paramount in the investigative community's efforts to recognize genetic, environmental, emotional, and dietary causes of digestive diseases. The recently established Digestive Disease Research Centers programs have been most productive and gratifying. Support is needed for continued success.

The American College of Gastroenterology strongly commends the accomplisnments of the Digestive Disease Advisory Board whose strategy for the prevention and ultimate treatment of digestive diseases is well recognized. The Digestive Disease Epidemiology Data System deserves special recognition in accumulation of valuable data. Expression of appreciation should be directed to the Digestive Disease Education and Information Clearinghouse which has been a source of knowledge that is disseminated both to professional and lay organizations. This concludes my testimony, Mr. Chairman. I am pleased to respond to any questions you may have.

Dr. **Farrar**. Our next speaker is Dr. William Silen.

Dr. **Silen**. Mr. Chairman, and members of the subcommittee, I am pleased to appear before you today to speak in support of the Digestive Diseases Research Centers program at NIADDK. I am William Silen, Director of the Harvard Digestive Disease Research Center that is a shared effort of the facilities at Harvard University, Beth Israel Hospital, and Brigham & Women's Hospital in Boston, Massachusetts.

The National Institute of Arthritis, Diabetes, Digestive and Kidney Disease has recently established ten digestive disease research centers to enhance the effectiveness of groups of research scientists who study digestive diseases and disorders. There are now 13 federally supported centers devoted to the study of diseases of the digestive system and nutrition. These centers are located throughout the United States and focus their research on the following disorders: liver diseases, G.I. motility, relationships between structure and function, inflammatory bowl diseased, GLIL secretion and absorption, diarrheal diseases, and G.I. hormones.

Each of these centers brings together both basic scientists, such as immunologists and biochemists, and clinicians, such as gastroenterologists, surgeons, endoscopists, and radiologists. The centers make possible cooperative research among these investigators by making centralized resources available for research projects and by encouraging scientists to develop new investigations and collaborations in the area of digestive diseases. It is this type of effort which will make the advances in diagnosis and treatment of the disease which keep 200,000 people out of work daily in our country, resulting in current costs of $50 billion a year in lost wages, reduced productivity, health care expenditures and disability payments.

This is an exceptional opportunity for me to advise you, because I can boast not only of the exciting research advances that are being made at the digestive diseases center at Harvard. But as well, the outstanding accomplishments in gastrointestinal investigation that are being conducted throughout the nation at other centers of excellence in digestive research.

Significant strides have already been made in the prevention and treatment of ulcer disease. In treating the debilitating effects of regional enteritis and ulcerative colitis, in understanding nutrient absorption and obesity, in treating chronic diseases of the liver and gallstones to name a few.

Mr. Chairman, since its creation in FY 1984, the digestive diseases research centers program has proved a fabulous window of opportunity for our field to study digestive diseases in a more coordinated, and more sophisticated manner.

In FY 85 all center grants in the NIADDK received a budget reduction of six percent to the amount recommended for the award by the peer review study sections. Similarly in FY 86 all center awards are to have the budget reductions of 13 percent. In fiscal year 1987, the proposed budget plan for the NIADDK reduces the budget for each center by 20 percent.

Proposed budget reductions for centers will impair the research efforts within these centers. Newly established collaborative efforts will be hampered, technical personnel will be lost, and the level of research efforts by teams of investigators will decline. The purpose of establishing these research centers will be contravened by the proposed budget plan. Furthermore, it can be anticipated that some newly established teams of investigators may be forced to disband and abandon their research into the causes and treatments of diseases and disorders of the digestive system.

The ultimate consequences of decrements in support of these center will have a major negative impact on the prevention and treatment of these extremely common diseases which are the leading cause of hospitalization and surgery in the country, affecting 20 million Americans each year, including 30 percent of all cancers.

I urge, Mr. Chairman, that everything possible be done to curb these budget reductions which will have such devastating effects on the health of American citizens and on the ultimate costs of medical care.

Thank you for the opportunity to present testimony to your subcommittee, Mr. Chairman. I am pleased to respond to any questions you may have.

[The statement of Dr. Silen follows:]

TESTIMONY OF

WILLIAM SILEN, M.D.
PROFESSOR OF SURGERY
HARVARD MEDICAL SCHOOL

AND

SURGEON-IN-CHIEF
BETH ISRAEL HOSPITAL
BOSTON, MASSACHUSETTS

DIRECTOR OF
DIGESTIVE DISEASE RESEARCH CENTER
AT
HARVARD MEDICAL SCHOOL

IN SUPPORT OF

THE DIGESTIVE DISEASE RESEARCH CENTERS PROGRAM

AT THE

NATIONAL INSTITUTE OF DIABETES,
DIGESTIVE AND KIDNEY DISEASES

ON

APRIL 28, 1986

Digestive
Disease
National
Coalition

(formerly Coalition of Digestive Disease Organizations)

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Founder & President Emeritus
Suzanne Rosenthal

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C. Digestive Disease Centers Program: $11.2 million. This level of funding would allow the NIDDK to continue the meritorious centers research grants currently being funded and fund two additional centers to study pancreatic disorders and pediatric GI diseases.

D. Clinical Nutrition Research Units: $4.2 million - maintain adequate support for Clinical Nutrition Research Units and add one more.

E. DD Advisory Board: $350,000. The outstanding efforts of the DD Advisory Board should be funded at a rate very similar to other advisory boards.

F. Epidemiology and Data System: $4.5 million. To support the substantial effort being conducted to establish liver transplant data, endoscopy data, and basic digestive data and information.

G. National Digestive Disease Education and Information Clearinghouse: $500,000. To support the current outstanding efforts to provide education and information to thousands of patients, family members and professionals concerned with diseases of the digestive system.

H. Specific Funding for Training of Research Specialists: $2 million. Allocated specifically to enable the NIDDK to keep our best scientists in academic medicine working on digestive disease problems. The DD division has 15 meritorious applicants, and under current constraints only 3 can be funded and no Research Career Development Awards can be funded.

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United Ostomy Association

Mr. Chairman and members of the subcommittee, I am pleased to appear before you today to speak in support of the Digestive Disease Research Centers program at NIDDK. I am William Silen, Director of the Digestive Disease Research Center that is a shared effort of the facilities at Harvard University, Beth Israel Hospital, and Brigham and Women's Hospital in Boston, Massachusetts.

The National Institute of Diabetes, Digestive and Kidney Disease (NIDDK) has recently established ten digestive disease research centers to enhance the effectiveness of groups of research scientists who study digestive diseases and disorders. There are now thirteen federally supported centers across the United States devoted to the study of diseases of the digestive system and nutrition. Each of these centers brings together both basic scientists, such as immunologist and biochemists, and clinicians, such as surgeons, endoscopists, and radiologists. The centers make possible cooperative research among these investigators by making centralized resources available for research projects and by encouraging scientists to develop new investigations and collaborations in the area of digestive diseases.

This is an exceptional opportunity for me to advise you, because I can not only boast of the exciting research advances that are being made at the DD Center at Harvard, but as well, the outstanding accomplishments in gastrointestinal investigation that are being conducted throughtout the nation at the other centers of excellence in digestive research.

Using the shared facilities of Harvard University, Beth Israel Hospital and Brigham and Women's Hospital in Boston, I lead a group of investigators studying the structure and function of the smooth muscle and the epithelium throughout the digestive tract. This research may lead to a better understanding of various digestive tract processes, such as the defense mechanisms that protect the stomach and duodenum against injury from gastric acid secretions.

The center at the New England Medical Center in Boston is under the direction of Dr. Mark Donowitz, and is involved in studying 1) the processes by which materials are absorbed into and secreted out of the body through the gastrointestinal tract, and 2) the diseases that can arise from abnormalities in these processes, especially diarrhea, malabsorption syndromes, and jaundice.

Dr. Don Powell is the director of the center located at the University of North Carolina at Chapel Hill. Scientists at this center are focusing their research on diarrhea, irritable bowel syndrome, and inflammatory bowel disease. A unique aspect of this center is its collaboration with North Carolina State University's School of Veterinary Medicine, where animal models for the study of these diseases may be developed.

Dr. William Snape directs the new digestive disease research center at the Harbor-UCLA Medical Center in Torrance, California, which is devoted to the study of inflammatory bowel disease. Two areas of research emphasis are examining immunologic responses of IBD patients and mapping genetic abnormalities that may determine a person's predisposition for IBD.

Research at the center located at the Mayo Clinic and Foundation in Rochester, Minnesota is under the direction of Dr. Sidney Phillips and is focused on the control of several functions of the digestive tract, including digestion, absorption and motility. In addition, investigators at this center are studying common diseases that result when these functions are disturbed. These diseases include non-ulcer dyspepsia, functional diarrhea, irritable bowel syndrome, and constipation.

Dr. Tadataka Yamada directs the research at the University of Michigan at Ann Arbor, where scientists are studying gastrointestinal peptide hormones, which are involved in appetite regulation, digestion, motility, secretion, and nutrient absorption. Research advances from this work may help researchers better understand the role of gut hormones in the development of a wide range of illnesses, such as obesity, peptic ulcer, irritable bowel syndrome, and diarrhea.

Dr. James Christensen oversees the activities of the center located at the University of Iowa in Iowa City, where investigations are focused on the mechanisms of gastrointestinal motility, absorption and transport processes, and the neuroanatomy of the digestive tract. For example, one group of scientists is examining the effects of exercise on motility in the digestive tract. Results of this work may help to explain why long distance runners and other participants in intense exercise often experience nausea, abdominal cramps, and sometimes bloody diarrhea.

The center at Yale University in New Haven, Connecticut is under the direction of Dr. James Boyer and is devoted to the study of liver structure, function, and disease. This center studies 1) liver transport function and bile formation; 2) bilirubin metabolism and the effects of alcohol; 3) mechanisms of liver fibrogenesis; 4) blood flow to the liver and other digestive organs; and 5) the evolution of chronic liver disease treatments, including liver transplantation.

Dr. Joseph Bloomer directs the liver center at the University of Minnesota at St. Paul. Research at this center is focused in three areas: 1) abnormal liver metabolism due to both inherited and acquired liver disorders; 2) liver damage due to viral hepatitis; and 3) liver transplantation.

Dr. Francis Simon directs the hepatobiliary research center at the University of Colorado at Denver where researchers are concentrating their studies in 1) bile secretion disorders, which may be involved in drug toxicity, cholesterol gallstone disease, and jaundice; 2) disorders of liver lipid metabolism, which may cause cholesterol gallstones and atherosclerosis; and 3) liver cell injury caused by hepatitis B, drugs, metals, and liver cancer.

Mr. Chairman, since its creation in fiscal year 1984, the Digestive Disease Research Centers program has proved a fabulous window of opportunity for our field to study digestive diseases in a more coordinated, and more sophisticated manner. To continue this progressive effort, I, on behalf of the centers directors would like to encourage your subcommittee to include an adequate amount of funding for continuation of existing centers projects, and for the addition of two more comprehensive centers that would complement current programs by studying pancreatic disorders and sorely needed pediatric gastrointestinal disease research.

Thank you for the opportunity to present testimony to your subcommittee, Mr. Chairman. I am pleased to respond to any questions you may have.

Mr. **Natcher**. Thank you very much, Dr. Silen. You made an excellent statement. We appreciate your appearance.

Dr. **Farrar**. Our next speaker is Bettie Jean Howard.

Mr. **Natcher**. All right. We will be pleased to hear from you.

Ms. **Howard**. Mr. Chairman, I am pleased to appear before you today on behalf of the Digestive Disease National Coalition. I am a registered nurse clinician, assigned to a surgical endocopic unit at the University of Maryland Hospital in Baltimore. I am also a member of the Society of Gastrointestinal Assistants and their government liaison to those organizations concerned with the prevention, treatment, and control of digestive diseases through improvement and expansion of research, training and education programs.

It is a fact that one of ten Americans suffer digestive problems, 20,000,000 have a chronic digestive diseases. Digestive disorders are the number one cause of hospitalization and surgery. This trend is partially due to the fact that most persons are reluctant to talk openly about digestive problems due to embarrassment and fear of rejection from peers, thus avoiding medical intervention. Their hope on the horizon is research, or a clinical research program that might help now. This can only be possible by government making every effort to support research training and research career awards.

The nurse is the direct care giver and the person most involved inpatient assessment, planning, implementation of care and evaluation of the patient's progress toward a mutually agreed goal. She makes a commitment to become a patient advocate within the health care delivery system. Patients have the right to know not only what is being done to them, but also what is being planned, prescribed and researched for them.

Mr. Chairman, I appreciate the opportunity to present testimony to your subcommittee on behalf of the Digestive Disease National Coalition. I am pleased to respond to any questions you may have.

[The statement of Ms. Howard follows:]

Society of Gastrointestinal Assistants, Inc.
1070 Sibley Tower Rochester, New York 14604 (716) 546-7241

TESTIMONY OF

BETTIE JEAN HOWARD, R.N.
NURSE CLINICIAN I

ON BEHALF OF

SOCIETY OF GASTROINTESTINAL ASSISTANTS

AND THE

THE DIGESTIVE DISEASE NATIONAL COALITION

TO THE

COMMITTEE ON APPROPRIATIONS
LABOR, HEALTH AND HUMAN SERVICES
EDUCATION AND RELATED AGENCIES SUBCOMMITTEE
U.S. HOUSE OF REPRESENTATIVES

CONCERNING

FUNDING FOR HEALTH PROGRAMS

ON

APRIL 28, 1986

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(formerly Coalition of Digestive Disease Organizations)

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Founder & President Emeritus
Suzanne Rosenthal

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I wish to focus my testimony today on how I see this all relating to the patients that I care for.

It is a fact. . .

One of ten Americans suffer digestive problems, twenty million have a chronic digestive disease. Digestive disorders are the Number One cause of hospitalization and surgery. This trend is partially due to the fact that many persons are reluctant to talk openly about digestive problems due to embarrassment and fear of rejection from peers, thus evading medical intervention. Our patients need help in coping with a diagnosis that they cannot understand or which is difficult for them to accept. The impact of digestive disorders on the lives of patients and their families is often accelerated due to our inability to pinpoint causes and provide hope for the future. Their one hope on the horizon is research. As it carries out its research mission, the National Institutes of Health's development of effective therapies for preventive diagnosis, and treatment of diseases within the digestive tract will touch a great segment of my patients of various ages.

Kathy, a young female patient with Crohns Disease (an inflammatory bowel disease) returns periodically for follow-up care. She wants to have a baby, but her physician has advised against pregnancy at this time. The drugs that she must take to control the disease with its embarrassing and stressful symptoms are known to be harmful to the fetus. She wants to know what is being done to find the cause for this disease, and will less toxic medicines be developed? Her only hope is a strong commitment to a fundamental research program which might answer her promise for the future or a clinical research program that might help her now. This can only be possible by the government making every effort to support research training and research career awards.

Bill is a young father of two small children who was suddenly beset with rectal bleeding and diagnosed with cancer. Advances in the field of gastrointestinal endoscopy made his evaluation less stressful due to the new flexible fiberoptic instrumentation. The ability to make the diagnosis by direct tissue biopsies at the time of colonoscopy brought prompt surgical intervention. Post-operative maintenance dosages of chemotherapeutic drugs were given. Now two years later he is cancer free and leading a normal life with his family. Periodic evaluations will guard against reoccurence. All this was made possible through the sharing of fundamental research knowledge among the Institute's investigators, and strong commitments to a comprehensive research effort.

In the geriatric population patients with diverticulosis (pockets which form on the wall of the large bowel, collect food particles and sometimes become infected), suffer recurrent abdominal pain which can interrupt their daily activities. The cause is not known, they express feelings of dispair, hopelessness and anxiety for their future. Will I be a burden? Will this get worse? Their hope is again support of research programs, and preventive educational programs.

The affects of emotions and stress known as functional gastrointestinal disease presents a diversity of symptoms in all age groups. Providing my patients with a scientific explanation of this phenomenon is difficult. It has presented in patients as a result of child abuse, drug abuse, in fellow workers as a result of stress in the work place, divorce, graduate schooling. Being a part of the MIEMS Shock Trauma Center, I see these patients presenting further life threatening complications of gastrointestinal bleeding. Endoscopy shows this to be caused by stress ulcers. The physiological explanation of all this is still not clear, the one hope on the horizon is a comprehensive research effort.

These are but a few examples of how intramural and extramural research programs throughout the Institutes and NIH filter down to the patient, the family and the nurse. The nurse is the direct care giver and the person most involved in patient assessment, planning, implementation of care and evaluation of the patients progress toward a mutually agreed goal. She makes a commitment to become a patient advocate within the health care delivery system. Patients have the right to know not only what is being done to them, but also what is being planned, prescribed and researched for them. Development of new methods of prevention diagnosis and treatment of disease can result in enormous cost savings and increased safety, especially i patients at high risk, and a more rapid return to norma activities.

There is a staggering need to identify, develop and promot digestive disease education/information programs focusing on prevention, to develop new modalities of treatment, to identify etiologies that are unknown and to continue the training of health care professionals in the field of research to accomplish these goals.

Mr. Chairman, I appreciate the opportunity to present testimony to your subcommittee on behalf of the Digestive Disease National Coalition and Society of Gastrointestinal Assistants. I am pleased to respond to any questions you may have.

Bettie Jean Howard, R.N.
Nurse Clinician I

Mr. **Natcher**. That was an excellent statement. We appreciate your appearance.

Dr. **Farrar**. Our next witness is Ms. Tracy Cirella, representing the American Liver Foundation.

Ms. **Cirella**. Good afternoon. My name is Tracy Cirella. I am 18 years old and very grateful to be alive. I am a senior at Hal Hollow Hills High School in East Dix Hills, Long Island and I coach an 8th grade girls soccer team and play badminton on the varsity team.

Last summer, I was involved in an automobile accident that almost took my life. But it wasn't the accident that threatened my life, it was a transfusion of infected blood that was the culprit. Some internal bleeding caused by several fractures in my pelvis made it necessary for me to have a blood transfusion. The blood I received contained a treacherous hepatitis virus. Do you know that there is no screening test available to identify this particular virus in the blood, nor is there any effective drug to render it harmless?

In addition, the doctors had a difficult time diagnosing what was happening to me because of appropriate laboratory tests to identify non A non B hepatitis. Just six weeks after my transfusion I was deathly ill. The virus had virtually destroyed my liver and I lapsed into a coma. My only chance for survival was a liver transplant. There simply was no other treatment. My father arranged to have me flown by helicopter from Long Island to Deaconess Hospital in Boston.

Again, I am very lucky. When I was desperately in need of a liver transplant the parents of a 15 year old girl in Chicago, who was dying with a cerebral hemorrhage, decided to donate her organs and I received her liver. I am also lucky because my liver transplant was successfully done by the highly skilled transplant team at the Deaconess.

It was touch and go for several weeks following my surgery. My body was trying to reject my new liver and at the same time I was trying to fight off a viral infection that flared up because of the antirejection drugs I had to take. It was really scary for me and devatating for my family. They are still terribly concerned about my future with my new liver and all the medicine I will have to take to keep from rejecting it.

I am extremely grateful to be alive and talking to you right now. But, gentlemen, if there had been a test to screen the blood I received or an anti-viral agent to fight the hepatitus that destroyed my liver, I wouldn't have needed the liver transplant. I came here today because I wanted my personal story to emphasize the need for more research. You hold the purse strings and can provide the funds. When you do, you will be preventing tragedies like mind and avoiding the tremendous cost of liver transplants. My operation cost $250,000, plus an additional $30,000 that my parents spent to be with me each day during my two and a half month hospital stay. To avoid rejecting my liver, I will have to take cyclosporin every day at an additional cost of $6,000 each year.

I am grateful for the medical miracle that saved my life. And we can count on many more miracles if the dollars are made available now.

We know that ten to fourteen percent of the four million Americans who receive blood each year will develop hepatitis. As one of those unlucky people, I ask you to please increase the funding for research to save other kids and their parents from having to go through the experience we did.

My parents and I are doing all we can to help the American Liver Foundation raise funds for liver research. But we are counting on you to provide the funds that will guarantee continued progress to save lives.

The American Liver Foundation recommends the continued support of efforts to prevent digestive diseases, to improve medical treatments and to find cures. We ask you to consider the following levels of funding for fiscal year 1987:

National Institute of Diabetes, Digestive and Kidney Diseases, $499,000,000.

Conte Digestive Diseases Centers Program, $12,000,000.

National Digestive Diseases Advisory Board, $350,000.

National Digestive Diseases Information Clearinghouse, $500,000.

Digestive Diseases Epidemiology Data System, $4,500,000.

Mr. NATCHER. Thank you very much, Ms. Cirella, we appreciate your appearance before our committee. You have made an excellent statement.

Ms. CIRELLA. Thank you very much.

Dr. FARRAR. Our last speaker is Dr. Donald Wilson.

Mr. NATCHER. Dr. Wilson, we will be pleased to hear from you. You have been before our committee before.

Dr. WILSON. Chairman Natcher, I am Dr. Donald E. Wilson, Professor and Chairman of the Department of Medicine, SUNY Health Science Center in Brooklyn, New York. The National Digestive Disease Advisory Board is a quasi-governmental agency and as Chairman of this board I would like to review several areas of particular concern to us.

Congress established the board in 1980 to review and evaluate the implementation of the national long range plan developed by the National Commission on Digestive Diseases in 1979 and to report annually to Congress and the Secretary of HHS on progress, on recommendations for future policies and programs and on fiscal support for digestive diseases.

Digestive diseases are the primary cause for major surgery in the United States and account for ten percent of our total economic disease burden. Our understanding of the causes and our ability to treat digestive diseases has improved. We can now treat medically over 95 percent of patients with peptic ulcer disease, dramatically reducing the need for surgery in this disorder.

We can prevent infectious diseases such as viral hepatitis.

We have made an important first step. However, many of the commission's recommendations have not been implemented because of budgetary restrictions. This concerns the board, particularly in light of new advances and promising opportunities. We are aware of the current efforts to reduce federal expenditures. However, support of efforts to reduce the economic impact of digestive diseases will be cost effective.

I would like to direct your attention to four priority areas of concern with the Administration's fiscal year 1987 proposal:

The percentage of funded approved individual research grants has declined from 45 percent a few years ago to 25 percent in 1985 with further reductions scheduled in 1986 and 1987 under the Administration's proposals. We have reached a point where research of excellent quality from talented scientists cannot be funded. Moreover, under the Administration's proposals, the budgets of those grants funded will be reduced approximately 20 percent in 1987 after reduction of six percent and approximately 13 percent in 1985 and 1986. We will lose productive investigators, reduce or prevent the development of new investigators with new ideas and hobble the ability of funded investigators to preform meaningful research.

The board recommends a total budget of $503,000,000 for NIDDK in order to provide minimum support for research related to digestive diseases.

Digestive disease centers provide an excellent mechanism to focus first rate, multidisciplinary research on a serious health end. Through FY 85 12 centers were funded throughout the United States. These centers have sustained budget reductions of six percent in 1985, 13 percent in 1986 and 20 percent in 1987. The purposes of establishing these centers will be contravened by proposed budget plans and we anticipate that teams of investigators will be forced to disband their research efforts.

Moreover, the current centers have not yet addressed several important areas, i.e., pediatric research and pancreatic diseases.

Another priority—the development of comprehensive centers—i.e., centers including health demonstration projects and community activities as a part of their overall effort cannot occur without new funding.

The board recommends that an additional $2,500,000 be provided to fund two additional centers, to provide full funding to existing centers, and to provide planning funding for the development of a limited number of comprehensive centers.

Our third concern is for the development of present and future manpower. There are appropriate mechanisms available to support promising young investigators, such as the clinical investigator, physician-scientists and research career development awards. The NIDDK budget has become so restricted that without new funds there will be a severe decline in the ability to train and support new investigators.

The board recommends increased funding sufficient to award ten new research career development awards in 1987.

In P.L. 99-158, Congress authorized the establishment of the national digestive diseases data system to collect, store, analyze, retrieve, and disseminate data derived from our digestive diseases populations. Unfortunately, funds have not been appropriated for this purpose. Without this system we cannot collect and analyze the epidemiologic data essential for biomedical research, patient care and public policy.

The board recommends that an additional $2,000,000 be provided to support the national digestive diseases data system.

Chairman Natcher, thank you very much for the opportunity to appear.

Mr. NATCHER. Thank you very much, Dr. Wilson. You made an excellent statement and we appreciate your appearance before our committee.

[The statement of Dr. Wilson follows:]

STATEMENT OF DONALD E. WILSON, M.D.

Chairman, National Digestive Diseases Advisory Board

Before the House Subcommittee on Labor, Health and Human Services
and Education and Related Agencies on Appropriations

(Appropriations for Digestive Diseases-Related Research - NIH)

Monday, April 28, 1986

I am Dr. Donald E. Wilson, Chairman, Department of Medicine, SUNY Health Science Center in Brooklyn, New York, and Chairman of the National Digestive Diseases Advisory Board. I am pleased to have the opportunity of speaking to you on behalf of the Board about important accomplishments and opportunities in digestive diseases research.

Congress established the National Digestive Diseases Advisory Board to review and evaluate the implementation of the National Long-Range Plan formulated by the National Commission on Digestive Diseases in 1979 and to report annually to Congress and the Secretary of Health and Human Services on recommendations for future policies, programs, and budget requirements related to digestive diseases. Our most recent annual report will be provided to the subcommittee today. The report describes advances, opportunities, and needs in digestive diseases research.

In establishing the National Digestive Diseases Advisory Board, Congress confirmed the significance of digestive diseases as a major public health issue. Digestive diseases rank second only to cardiovascular diseases as a cause of disability due to illness in the U.S. More than 34 million Americans are affected with diseases of the digestive system, 20 million of whom have chronic disorders. These diseases include more than 40 acute and chronic gastrointestinal conditions, ranging from common illnesses such as gallstones, diarrhea, and hemorrhoids to more serious, often life-threatening diseases such as liver cirrhosis, inflammatory bowel disease, and cancer. Digestive diseases are a leading cause of hospitalization and the primary reason for major surgery in this country. Together, digestive diseases represent 10 percent of the total economic burden of disease in the U.S.

Advances in biomedical research have expanded our understanding of the development of digestive diseases and consequently improved our ability to diagnose and treat these diseases, often preventing recurrence of symptoms or serious complications. The treatment of a variety of digestive diseases such as peptic ulcers, gallstones, and infectious diarrhea has improved markedly over the past few years. In addition, the development and therapeutic use of the flexible, steerable endoscope has improved the diagnosis and treatment of several digestive diseases and reduced the need for surgery in many cases. Such advances have begun to reduce the burden of morbidity, mortality, and health care costs associated with digestive diseases.

Despite these advances, the effort to reduce and eventually prevent digestive diseases has only begun. The long-range plan formulated by the National Commission on Digestive Diseases focused the attention of policy makers, health professionals, and the public on the widespread impact of digestive diseases on the Nation. Progress has been made toward achieving a few of the goals of the long-range plan (see attached status report on the Commission's recommendations). However, many of the Commission's recommendations have not been implemented because of budgetary restrictions. This lack of financial resources is a major cause of concern by the Board, especially in light of the new and promising opportunities for advances in the prevention, treatment, and early diagnosis of these disorders.

The Board is aware of the current effort to reduce Federal expenditures. However, support of biomedical research directed to reducing digestive diseases is a cost-effective investment that will yield considerable return in succeeding years. Therefore, the Board would like to direct the Subcommittee's attention to four priority areas of concern within the Administration's fiscal year 1987 proposal: support for individual research grants, support for digestive disease centers, support for research manpower programs, and support for the digestive diseases data system.

Digestive Diseases Research Grants: Despite the advances in digestive disease-related science, the appropriations for individual research grants in digestive diseases have not kept pace with the needs and opportunities in this area. As a result, the percentage of approved research grants that can be funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) has declined steadily, from about 45 percent a few years ago to approximately 25 percent in fiscal year 1985. This rate will be reduced even further in fiscal years 1986 and 1987 under administration proposals. Similar reductions have occurred in all research programs supported by the National Institutes of Health. This trend, if continued, will significantly hinder or prevent many exciting research projects.

Research grant applications are reviewed by expert panels of scientists and ranked from 100 to 500, with the highest possible score being 100. A score of 225 or better is generally considered to reflect excellent quality. Under the Administration's budget for fiscal year 1987, the priority score cut-off for digestive diseases grants within NIDDK will be approximately 150, the lowest level in history. Many of the unfunded grants will be from talented new investigators applying for their first research grant; others will be from eminent investigators with a long history of contribution to the field. We have worked long and hard to attract such individuals to digestive diseases research. Some of these scientists may be forced to abandon their research efforts.

In addition to the problem of the low priority score cut-off, the budgets of all funded applications will be severely reduced below recommended levels. In fiscal year 1985, all grant budgets in NIDDK were reduced approximately six percent; in fiscal year 1986, budgets will be reduced approximately thirteen percent; and in fiscal year 1987, under the administration's proposals, budgets will be reduced approximately twenty percent. Under these circumstances, few scientists will be able to maintain effective research projects. Digestive diseases research will be severely hindered if additional funds are not provided for individual research grants.

- The Board recommends a total budget of $503 million for NIDDK to provide a minimum level of support for individual research grants and for other NIDDK programs related to digestive diseases.

Digestive Diseases Research Centers: Our second area of concern is for the recently authorized program of digestive diseases research centers. This program enables clinical and basic scientists to join together in a coordinated multidisciplinary approach to the complex research problems posed by digestive diseases. In fiscal year 1984, the Congress provided sufficient funds to establish six new digestive diseases (DD) research centers. In fiscal year 1985 four additional DD centers were established to bring the total number of DD centers funded by the NIDDK to twelve. These DD research centers are located throughout the United States.

In fiscal year 1985 all centers received a budget reduction of 6 percent from the amount recommended by the peer review study sections. Similarly in fiscal year 1986, all centers are to have budget reductions of 13 percent. In fiscal year 1987, the administration's proposal would reduce each budget by 20 percent. These reductions will seriously impair the research efforts within each center, newly established collaborative efforts will be hampered, and valuable personnel will be lost. The purpose of establishing these research centers will be contravened by the proposed budget plan. Furthermore, it can be anticipated that some newly established teams of investigators may be forced to disband their research into the causes and treatments of diseases and disorders of the digestive system.

The present portfolio of center grants does not yet include research activity in two areas designated by the Board as needing attention, viz., pancreatic disorders and pediatric digestive diseases research. These two areas appear to be ready for a level of effort that a center could bring to research in these two important, but neglected fields. In addition, some of the DD centers appear to be ready for development into comprehensive centers, that is, centers which have a component of health demonstration projects and community activities together with the research component. In order to assure the orderly development of these components in existing research centers, funds are requested to provide planning grants for this purpose. A limited number of comprehensive centers in DD are anticipated.

- The Board recommends that an additional $2.5 million be provided for two additional digestive diseases centers; for planning grants for a limited number of comprehensive centers; and for full funding of existing centers at recommended levels.

Digestive Diseases Research Manpower: Our third area of concern is for digestive diseases research manpower. Excellent award mechanisms are available to support promising young investigators. However, the NIDDK budget for training grants and individual career development awards has become so restricted that we anticipate a very severe decline in capacity to support future candidates. There are 3 types of individual career development award mechanisms used by NIDDK to support digestive diseases research. Two of these, the Clinical Investigator Award and the Physician-Scientist Award are key to providing adequate opportunity for M.D.'s to acquire sufficient research training and experience to become qualified as independent investigators. The third mechanism, the Research Career Development Award, enables the young established investigator, either Ph.D. or M.D., who is otherwise burdened with non-research academic duties, to be dedicated entirely to research during a very crucial stage of career development. Under current constraints, very few awards will be made.

- The Board recommends increased funding for the research career development of M.D.'s and Ph.D.'s in basic science areas related to digestive diseases to permit 10 new awards in fiscal year 1987.

Digestive Diseases Data System: Our fourth area of concern involves the establishment of the National Digestive Diseases Data System recommended by the National Commission on Digestive Diseases and authorized by Congress in P.L. 99-158. The data system will provide an ongoing mechanism to collect and analyze the epidemiologic data essential for biomedical research, patient care, and public policy. The first step is to ascertain the natural incidence and prevalence of defined digestive diseases. P.L. 99-158 authorized a National Digestive Diseases Data System to collect, store, analyze, retrieve, and disseminate data derived from a patient population with digestive diseases for the purpose of detecting individuals at risk of developing digestive diseases. Unfortunately funds have not been appropriated for this purpose.

- The Board recommends that an additional $2 million be provided to support the National Digestive Diseases Data System.

We appreciate your support for digestive diseases and your efforts to improve the nation's health. Thank you for the privilege of appearing before your Subcommittee. I will be pleased to respond to any questions you may have.

4/17/86

STATUS OF THE RECOMMENDATIONS
NATIONAL COMMISSION ON DIGESTIVE DISEASES
(Recommendations published January 31, 1979)

Recommendations 1 through 10 proposed actions that were considered to yield results in the immediate or near future.

1. Establish a National Digestive Diseases Education and Information Clearinghouse (page 17)

A National Digestive Diseases Education and Information Clearinghouse (NDDEIC) should be established under the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD) to serve as a national educational resource for patients with digestive diseases and their families, physicians and other health professionals, and the general public, especially its neglected segments, such as rural Americans, the elderly, minority groups, and children. It should be funded separately from other ongoing activities of the Institute. However, NIAMDD should seek ways of having the NDDEIC work economically with the arthritis and diabetes clearinghouses.

The Clearinghouse has been established within the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK). It serves as a central resource to promote exchange of information between professional and voluntary health organizations. The Clearinghouse shares support services, and a Combined Health Information Database, with the arthritis and diabetes clearinghouses.

2. Establish Standards in Training of Physicians (page 19)

The Fogarty International Center (FIC) of the National Institutes of Health should be provided funds to support efforts to review the requirements in teaching personnel, facilities, clinical experience, and curricula necessary to provide an adequate educational experience for physicians seeking advanced qualifications in gastroenterology. To implement this recommendation:

- Such efforts should be made in collaboration with the American Board of Internal Medicine, the American Board of Pediatrics, and the respective residency review committees.

Funds have not been appropriated to the Fogarty International Center to support this activity.

- The conclusions should be disseminated to persons involved with the training of digestive diseases specialists and serve as a stimulus for appropriate residency review committees to propose to the Liaison Committee on Graduate Medical Education minimum standards for programs approved for training in gastroenterology.

As a corollary action, boards that qualify specialists in family practice, general pediatrics, general internal medicine, general surgery, pathology, and radiology should review their requirements pertaining to the experience necessary for treating digestive diseases.

Representatives of the American Society of Gastrointestinal Endoscopy and the Council of the Federation of Digestive Diseases Societies should collaborate with the Joint Commission on Accreditation of Hospitals to establish and implement requirements for training and experience that would qualify practitioners to perform endoscopy in the hospital setting and to insure that their competence in the use of the procedure is reviewed by involved medical staffs.

3. Strengthen Professional Education in Digestive Diseases (page 20)

The National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD) should be authorized to strengthen educational programs in digestive diseases in medical schools, and funds should be appropriated for this purpose.

- Twelve digestive disease teaching awards in the first year, 14 in the second, and 16 in the third, analogous to those in the field of pulmonary diseases, each valued at up to $30,000 per year, should be established.

Funds have not been appropriated for this purpose.

- Funds for faculty from other institutions should be provided to supplement teaching programs pertaining to digestive diseasees in the basic science and clinical departments of medical schools where faculty involvement or expertise in digestive diseases is lacking.

- Teaching programs that focus on the psychosomatic aspects of digestive diseases should be encouraged and should constitute a significant proportion of total instruction in gastroenterology. Three annual workshops should be held on educational strategies in the behavioral aspects of digestive diseases, jointly sponsored by NIAMDD and the National Institute of Mental Health (NIMH).

4. Standardize Terminology and Diagnostic Criteria (page 22)

The Fogarty International Center (FIC) of the National Institutes of Health should be provided funds to support workshops on digestive diseases to standardize nomenclature, diagnostic criteria, diagnostic methodology, and measures of functional disability. The workshops should be held in collaboration with concerned Federal agencies, national professional groups, and international bodies. The published proceedings of the workshops should be disseminated to persons concerned with research, patient care, patient billing forms, and insurance data. Advice and assistance should be sought from the American Medical Association's Committees on Current Medical Information Terminology and Current Procedural Terminology, the World Health Organization, and from medical record societies.

Funds have not been appropriated to the FIC for this purpose. However, members of the National Digestive Diseases Advisory Board (NDDAB) and NIDDK staff have reviewed the International Classification of Diseases (the 8th and 9th editions) and identified numerous digestive disease-related codes not previously identified as such. Dr. Johannes of NIDDK subsequently developed a system to cross index these digestive disease codes. The Board has encouraged the completion and publication of this system.

5. Aid Physicians in Constructing Sequences of Diagnostic Tests (page 22) The National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD) should support research directed at aiding practicing physicians in making proper sequences of diagnostic tests for specific conditions in order to spare the patient unnecessary tests and to achieve cost containment.	No related research has been undertaken by NIDDK. Expensive clinical trials would be required in many instances. However, the NDDAB initiated an effort to develop a mechanism that could substitute for clinical trials in some instances. The NDDAB's model involved the application of decision analysis to screening high-risk populations for colorectal cancer.
6. Expand Translational and Clinical Health Services Research (page 23) The National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD), the National Institute of Allergy and Infectious Diseases (NIAID), the Center for Disease Control (CDC) and other concerned Federal agencies should increase their support for clinical health services studies and translational research in digestive diseases-related areas.	Funds have not been appropriated to any of the cited agencies to support this recommendation.
7. Strengthen Digestive Diseases Programs in the Department of Defense (page 25) The Department of Defense should receive support to enlarge its program in digestive disease research and training.	Funds have not been appropriated for this recommendation.
8. Encourage the Role of the Veterans Administration in Digestive Diseases Research (page 25) The Veterans Administration (VA) should be encouraged to: • Continue and expand its clinical research and clinical trials in digestive diseases.	The Veterans Administration has not received additional appropriations for programs targeted toward diabetes.

• Establish a special program in Veterans Administration Hospitals for diagnosis and treatment of common digestive diseases, especially those associated with alcoholism and drug abuse.	
9. Support Training Programs in Digestive Diseases Research (page 26) The National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD), the National Institute of Allergy and Infectious Diseases (NIAID), and the Center for Disease Control (CDC) should receive additional funds for, and the National Cancer Institute (NCI) and the Veterans Administration should be encouraged to strengthen, their training programs in research in digestive diseases.	Appropriations for training programs have not been increased; recent appropriation trends are toward fewer awards.
10. Expand Applied (Clinical) Research in Digestive Diseases (page 27) Appropriations of the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD), the National Institute of Allergy and Infectious Diseases (NIAID), the National Cancer Institute (NCI), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Aging (NIA), and the Center for Disease Control (CDC) should be increased substantially to permit expansion of the resources allocated to research applied to digestive disease problems. The increase recommended is designed to take advantage of the great opportunities available now, as identified in the research reports submitted to the Commission. The increase would expedite the rapid transfer of biomedical and behavioral research to the problems of patient care. The Commission recommends primary emphasis on investigator-initiated research grants as the mechanism of support for these activities.	Appropriations for digestive diseases research projects have increased an average of seven percent per year since 1979 (based on 1979 constant dollars). However, the percentage of approved research applications that can be funded declined from approximately 45 percent in 1979 to 25 percent in 1985. The recommended staff positions have not been provided. In fact, overall staff positions within NIDDK and other NIH institutes have decreased significantly in the past two years.

The institutes listed above and the National Institute of Child Health and Human Development (NICHD) should coordinate their efforts to stimulate research activity in digestive diseases. In order to responsibly administer the research programs recommended in this report, 16 additional staff positions in the first year, 24 in the second year, and 28 in the third year should be authorized for the extramural program in digestive diseases at NIAMDD.	

Recommendations 11 through 16 focused on the generation of new knowledge through research, to facilitate the advancement from "halfway" technology to high technology.

11. Expand Basic Research in Digestive Diseases (page 37) Future progress in digestive disease depends in many instances upon the solutions to fundamental biological questions. The Commission recommends that the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMMD), the National Institute of Allergy and Infectious Diseases (NIAID), the National Cancer Institute (NCI), and the National Institute of Child Health and Human Development (NICHD) increase their support of basic research in biomedical and behavioral sciences related to digestive disease. Expansion of basic research is the starting point for a continuum which extends to future improvements in health care.	Comments for #10 applicable here also.
12. Support Cooperative Research (page 40) The National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMDD) should fund increased cooperative research efforts in digestive diseases.	The establishment of digestive diseases research centers is related to this recommendation. These centers provide a unique mechanism for interdisciplinary and collaborative research.

13. Expand Intramural Research at the National Institutes of Health (page 41)

The intramural research program in digestive diseases of the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMMD) should be increased by 18 positions to permit recruiting over a 3-year period of 6 additional senior investigators, 6 clinical or research associates, and 6 support personnel.

One senior investigator position and one support position should be added to the intramural research program at the National Institute of Allergy and Infectious Diseases (NIAID) to enable expanded research efforts in hepatitis.

One senior investigator position and one support position should be added to the digestive disease-related intramural research program at the National Cancer Institute.

The recommended staff positions have not been provided. In fact, overall staff positions within NIDDK and other NIH institutes have decreased significantly in the past two years.

14. Determine Epidemiological Patterns of Digestive Diseases (page 42)

The National Center for Health Statistics (NCHS) should revise its presentation of data by bringing together data on all individual diseases identified by the Commission as digestive diseases to present a comprehensive picture of their prevalence and impact on the physical, emotional, and financial well-being of all Americans.

This revision should permit determinations of geographical patterns of illness and rate of occurrence among infants, children, adolescents, and adults of various ages.

The National Center for Health Statistics and the National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMMD) should collaborate in studies to ascertain the prevalence of

The Board supported three epidemiologic studies related to the prevalence and impact of digestive diseases (see Annual Report). The Centers for Disease Control and the Health Care Financing Administration assisted in two of the studies. The NIDDK is developing a National Digestive Disease Data System to continue the collection and analysis of related data.

specific major digestive diseases in suitably selected populations groups.

The National Institutes of Health, the Center for Disease Control (CDC), and other concerned Federal agencies should expand their funding of epidemiological studies of digestive disorders and the training of additional epidemiologists. Relevant areas of study should be identified through workshops.

15. Investigate the Toxicity of Environmental and Industrial Pollutants to the Digestive Tract (page 43)

The National Institute of Environmental Health Sciences (NIEHS), the National Institute for Occupational Safety and Health (NIOSH), and concerned lay organizations (such as industry and labor groups) should increase their efforts to collect and disseminate comprehensive data on hepatic and gastrointestinal injury caused by exposure to industrial and other environmental chemicals.

All concerned public and private agencies should give priority to the support of research in the pathogenesis, detection, prevention, and treatment of the injurious effects of industrial and environmental pollutants on the digestive organs.

Study of the following topics should be emphasized:

- Toxicologic and metabolic investigations, including absorption, metabolism, and elimination of chemical agents.
- The influence of nutrient deficits, smoking, consumption of alcoholic beverages, and use or abuse of various drugs on the toxic effects of industrial and environmental pollutants.

No known initiative has been undertaken in this area.

- Development of sensitive, specific, simple, noninvasive tests for detection of injury to the liver and other organs that may be applied in mass surveillance of workers in industry.

16. Study the Influence of Nutrition on Susceptibility to Digestive Diseases (page 44)

The National Institute of Arthritis, Metabolism, and Digestive Diseases (NIAMMD), the National Institute of Child Health and Human Development (NICHD), and the National Cancer Institute (NCI) should assign high priority to and be funded for long-term laboratory, clinical, and epidemiological research in the role of diet in the causation of digestive diseases.

No specific activities have been initiated. Existing Clinical Nutrition Research Units support related activities but the degree of specific digestive disease related research in those units is not known.

Recommendations 17 through 20 apply to general improvements in health care, with specific implications for digestive diseases.

17. Study Continuing Medical Education and Assess Manpower Needs (page 45)

Funds should be appropriated to the Health Resources Administration (HRA) for research to:

- Cosponsor with appropriate professional organizations a continuing study of the need for and current supply of digestive disease specialists in practice, research, teaching, and full-time academic positions.
- Study the relationship of quality of care and cost-effectiveness of medical care to the type and level of training of the health professional providing the care.
- Determine manpower requirements, curricula, educational facilities,

Funds have not been appropriated to support this recommendation.

duties, certification, licensing, and responsibilities of nonphysician health professionals.

- Investigate whether costs are lowered through the use of nonphysician health professionals and, if so, recommend third-party reimbursement procedures to promote fuller use of the health professionals (see Recommendation 18).

The Health Resources Administration, in collaboration with the proposed National Digestive Diseases Education and Information Clearinghouse, should support evaluations of the effectiveness of various teaching methods used in continuing medical education in digestive diseases.

18. Provide health Insurance Coverage for Patient Education (page 46)

The cost of educating patients about their digestive diseases, within the context of other aspects of medical care provided by both physicians and other health professionals, should be treated as a distinct reimbursable expense to be paid by medicare, Medicaid, and future government-financed health programs (see Recommendation 17). Private third-party carriers should be encouraged to follow this policy.

No progress has been made toward this recommendation.

19. Provide Health Insurance Benefits for Catastrophic Diseases (page 47)

Legislation should be enacted to provide insurance benefits to defray the catastrophic expenses (as defined by Congress) of major illness, including digestive diseases.

No action. However, the subject receives frequent Congressional interest and the Secretary, DHHS, revently gave high priority to the development of legislation to provide insurance benefits for catastrophic expenses of major illnesses.

20. Facilitate Progress in Digestive Diseases by Administrative Changes (page 48)

The Federal Office of Management and Budget (OMB) should exempt from its forms clearance requirements and procedures any medical and related behavioral research projects that are:

- Conducted in accordance with protocols that specify in advance the problem(s) to be addressed, the number of respondents required, the information to be collected from them, and the expected duration of the study.
- Covered by and approved under the Department of Health, Education, and Welfare regulations for the protection of human subjects (45 CFR 46).
- Based on voluntary participation by the respondent population.

An exemption from the policy of the Department of Health, Education, and Welfare to reduce conferences should be granted to conferences and/or workshops outlined in the long-range plan to combat digestive diseases.

No action.

Recommendations 21 through 23 are aimed at coordinating components of the national long-range plan.

21. Establish a National Digestive Diseases Advisory Board (page 49)

A National Digestive Diseases Advisory Board should be established to review, advise on, and facilitate coordination of Federal activities in digestive diseases. It should report directly to the Congress and the Secretary of the Department of Health, Education, and Welfare (DHEW).

The Board was established in October 1981 pursuant to P.L. 96-538. The Board was reauthorized in P.L. 99-158.

22. Ensure Representation for Digestive Diseases on Three Institute Advisory Councils (page 50) The National Cancer Institute (NCI), the National Institute of Allergy and Infectious Diseases (NIAID), and the National Institute of Alcohol Abuse and Alcoholism (NIAAA) should have on their advisory councils at least one individual with specialized knowledge of digestive diseases.	Digestive disease specialists are on the NCI, NIAID, and NIAAA Advisory Councils. In addition, the Board has directed its attention to the composition of the scientific review panels at the National Institutes of Health responsible for the evaluation of all research grant applications relevant to digestive diseases.
23. Provide Identity and Visibility to Digestive Diseases within the National Institutes of Health (page 50) Administrative measures should be undertaken by the National Institutes of Health (NIH) to emphasize the importance of the digestive diseases and to provide budgetary identity.	This recommendation was accomplished through the establishment of the Division of Digestive Diseases and Nutrition within NIDDK.

Mr. **Natcher**. It has been a good panel discussion, and we appreciate it and we have enjoyed it.

Dr. **Farrar**. Thank you very much.

Mr. **Natcher**. Thank you very much, ladies and gentlemen.

Monday, April 28, 1986.

NATIONAL INSTITUTE OF DIABETES, DIGESTIVE AND KIDNEY DISEASES

WITNESS

DR. RICHARD B. FREEMAN, THE INTERSOCIETY COUNCIL FOR RESEARCH OF THE KIDNEY AND URINARY TRACT

Mr. **Natcher**. Our next witness is Dr. Richard B. Freeman. Come around, Dr. Freeman, we will be pleased to hear from you at this time.

Dr. **Freeman**. Thank you, Mr. Chairman.

It is a pleasure to again have the privilege to be here and testify for you. My name is Richard B. Freeman. I am a Professor of Medicine, Chairman of the Digestive Disease Division at the University of Rochester. I am representing today the Intersociety Council for Research of the Kidney and Urinary Tract, which is made up of nine separate organizations, so if you can imagine that there would be nine members or officers of each individual organization sitting at this table, I am speaking for them.

You will hear from Dr. Vaughan tomorrow and specific problems in urology. I would like to not center on the recommendations that may have been made to you that you are already well aware of—the support for National Institutes of Health, for which we have been grateful, and the specific dollar amounts which have been made to you. I would like to center on one area that the Intersociety has proposed just last year.

When we appeared before the committee last year, we recommended that you consider funding six multidisciplinary institutional kidney urology centers. Your language from the committee, the report from the committee was very encouraging, which I quote in part:

> The center concept might provide the necessary framework and mechanism for the kidney urology community to transplant treatment for many citizens. The committee requests an evaluation of the proposal to establish up to six multidisciplinary, interinstitutional kidney urology centers to be funded after employing the usual and customary processes of the National Institutes of Health to insure the quality and scientific merit of hypertension and the kidney, diabetes mellitus and the kidney, obstructive and hereditary diseases of the urological system and the kidney, nutrition and the kidney, immunology and the kidney, and cellular injury and the kidney.

The Senate subcommittee directed the Secretary of HHS to have the National Institutes of Health study the proposal and National Institutes of Health responded and this is their language:

> The National Institutes of Health has evaluated the concept of establishing kidney and urological research centers within NIDDK and has concluded that research could be expected to benefit from a multidisiplinary and interdisiplinary approach provided by the centers research mechanism.

The report concluded:

> There is sufficient reason to believe that the proposed research centers program is scientifically feasible and that it would contribute positively to advances in research knowledge and thereapeutic approaches relative to ESRD and BPH. The National Institutes of Health is therefore supportive of the concept of kidney and urological diseases research centers, if resources were to be made available for this purpose.

We are aware of the tremendous cost of the medicare end state renal disease program. The outlays from federal trust funds are estimated between $2,500,000 and $3,000,000,000 per year through 1990. Current conservative surveys estimate that there are 22,000 new patients that will require treatment each year. Some estimate the numbers could be as high as 55,000 new patients a year.

The Intersociety Council believes that with intensification of research as proposed in the centers the number of new patients entering the ESRD program can be reduced substantially—approximately 25 percent—over the next decade, resulting in a remarkable reduction in the number of patients requiring treatment. This would lead to dramatic cost savings for the Federal Government.

Several examples, hypertension can be treated. Hypertension if controlled, will not lead to end state renal diseases and in understanding of diabetes, which accounts for 25 percent of the patients that reach the point of requiring dialysis, now seem to indicate that their disease would be at least stopped in its course, if not indeed turned around. There are many other examples.

I would also like to point out that the National Kidney Foundation and its 50 affiliates has designated a health promotion and education program to complement the research aspect of a six center concept. The professional and public education program will provide the demonstration component for the research and prevention centers and will be funded from the private sector.

The benefits to costs ration in terms of both dollars and the human condition, resulting from implementation of these six centers will be immense. As a person who sees patients, who does research, and teaches, I can assure you that this is important. I therefore, urge you in the most respectable terms to provide the funding for these six research and prevention centers.

Mr. Chairman, I again appreciate the opportunity to appear before the subcommittee and to again reiterate that the Intersociety Council does urge that you continue your most gracious and supportive energies to support the National Institutes of Health and its valuable contributions. If it were not for what was done in the past, with the RO-1 grants awards we would not at this point be able to say we feel there will be inroads made in NESRD treatments because of your previous support through RO-1 grant awards.

Thank you, Mr. Chairman.

Mr. NATCHER. Thank you very much. You have made an excellent statement and we appreciate your appearance. Thank you, sir.

[The statement of Dr. Freeman follows:]

THE INTERSOCIETY COUNCIL
for Research of the Kidney and Urinary Tract

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American Society of Pediatric Nephrology
American Society of Transplant Physicians
American Urological Association
National Kidney Foundation
Renal Physicians Association

American Association of Clinical Urologists
American Society of Artificial Internal Organs
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STATEMENT

of the

INTERSOCIETY COUNCIL
for Research of the Kidney and Urinary Tract

to the

Subcommittee on
Labor, Health and Human Services,
Education and Related Agencies
Committee on Appropriations
U.S. House of Representatives

Presented by

Richard B. Freeman, M.D.

RE: Appropriations in support of funding for the National Institutes of Health

April 28, 1986

Mr. Chairman and Members of the Subcommittee:

Thank you for providing me with the opportunity to comment on the appropriations for the National Institute of Diabetes, Digestive and Kidney Diseases (NIDDK), for the fiscal year 1987. I am Richard B. Freeman, M.D., Professor, Department of Medicine, University of Rochester, New York, and Immediate Past President of the Renal Physicians Association. I appear before you today representing the Intersociety Council on Kidney and Urological Diseases, which is made up of virtually all groups active in research and the treatment of kidney and urinary tract disorders, with 15,000 physician and 50,000 lay members.

When we appeared before this subcommittee last year we recommended that you consider funding six multidisciplinary/ multi-institutional kidney-urological centers. Your response in report language was encouraging. You noted:

> The center concept might provide the necessary framework and mechanism for the kidney-urology community to intensify the research advances to prevent dialysis and transplant treatment for many citizens. The Committee requests an evaluation of the proposal to establish up to six multidisciplinary, interinstitutional kidney-urology centers to be funded after employing the usual and customary processes of the National Institutes of Health to insure the quality and scientific merit of the proposals received. Those centers would be: hypertension and the kidney, diabetes mellitus and the kidney, obstructive and hereditary diseases of the urological system and the kidney, nutrition and the kidney, immunology and the kidney, and cellular injury and the kidney.

We were further encouraged by the report the National Institutes of Health transmitted to the Congress in February, 1986, as a result of the directive in the House HHS Appropriations subcommittee report language.

> The NIH has evaluated the concept of establishing kidney and urological research centers within NIADDK (now NIDDK) and has concluded that research could be expected to benefit from a multidisciplinary and interdisciplinary approach provided by the centers research mechanism...
>
> The report concluded:
>
> There is sufficient reason to believe that the proposed research centers program is scientifically feasible and that it would contribute positively to advances in research knowledge and therapeutic approaches relative to ESRD and BPH. The NIH is therefore supportive of the concept of kidney and urological diseases research centers, if resources were to be made available for this purpose.

We are aware of the tremendous cost of the Medicare End Stage Renal Disease Program. The outlays from federal trust funds are estimated between 2.5 and 3.0 billion dollars per year through 1990. We submit that the only practical way to reduce these outlays is to prevent new patients from advancing to the point where repetitive dialysis or transplantation is required to save their lives. Current conservative surveys estimate that there are 22,000 new patients that will require treatment each year. Some estimate the numbers could be as high as 55,000 new patients per year.

The Intersociety Council believes that with intensification of research as proposed in the centers the number of new patients entering the ESRD program can be reduced substantially (approximately 25%) over the next decade, resulting in a remarkable reduction in the number of patients requiring treatment. This would lead to dramatic cost savings for the federal government.

Mr. Chairman, it should be emphasized that last year was the first time the Kidney/Urology Community appeared before this subcommittee requesting directed funding for research initiatives. Indeed, the present body of knowledge has been developed through the traditional funding mechanisms of the National Institutes of Health. Until recently this has been appropriate for research needs and potential in the area of kidney and urological diseases. The time has arrived, however, for the science developed by individual investigators to be directed to a multidisciplinary and multi-institutional setting. We are now on the threshold of major advancements and this "state of the art" research in kidney and urinary tract diseases demands cooperation to assure its maximum benefits in human and economic terms.

The mission of each Research and Prevention center would be (1) to organize basic research aimed at factors which cause renal damage and develop approaches which prevent or reverse the deleterious effects, (2) to develop and execute appropriate clinical trials, and (3) to formalize prescriptions for treatments to reverse and prevent progression of renal disease.

The goal, which the Intersociety Council believes can be attained, is a profound reduction of the major causes of kidney diseases by the early 1990's.

You should also know that the National Kidney Foundation and its 50 affiliates has designed health promotion and education programs to complement the research aspect of the six center concept. This professional and public education program will provide the demonstration component for the Research and Prevention Centers and will be funded from the private sector.

The benefits-to-costs ratio - in terms of both dollars and the human condition - resulting from implementation of these six centers will be immense. I therefore respectfully urge you to provide the funding for these six Research and Prevention Centers.

Mr. Chairman, The Intersociety Council also urges the Committee to provide a level of support in fiscal year 1987, to assure 6,219 competing awards for the NIH. This would assure full support for 648 grants at the NIDDK.

Thank you.

MONDAY, APRIL 28, 1986.

EDUCATIONAL PROGRAMS

WITNESSES

GLENN COMBS, PRESIDENT, AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

F. LYNN MAY, EXECUTIVE DIRECTOR, AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Mr. NATCHER. Our next witnesses are Mr. Glenn Combs, Mr. M. Lynn May, and gentleman, come around.

We are delighted to have you gentlemen before the committee. We will be pleased to hear from you.

Mr. COMBS. Thank you, Chairman Natcher, I am pleased to inform you that recently the Kentucky General Assembly has passed legislation to recognize Physician Assistant practice. That makes our home state the 47th state in the country to formally recognize the benefits of the Physician Assistant practice. I don't have any tips in regard to the upcoming event. In fact, I was going to ask you the same question.

Mr. Chairman, on behalf of the American Academy of Physician Assistants, I want to thank you for this opportunity to testify on the Labor-HHS-Education appropriation bill for fiscal year 1987.

When I appeared before your committee last year, the Congress had not reauthorized funding or physician assistant programs. I am pleased to be able to come before you this year with the reauthorization complete. It is not clear, however, that the victory last fall really is worth much.

Subsequent to the enactment of PL 99-129, the Gramm-Rudman budget reductions took effect. Thus, even though Congress authorized and appropriated $4,800,000 for physician assistant education, only $4,300,000 is available. This means, Mr. Chairman, that some physician assistant programs that had been counting on federal assistance will not be receiving any federal funds in FY 1986.

The tragedy of this turn of events is not going to be readily noticeable. I feel confident that most programs that lost out on federal funds will continue to exist and turn out first class physician assistants. No, Mr. Chairman, the impact of Gramm-Rudman will not truly be felt for a few years, when future physician assistant program graduates make the decision on what type of medicine to pursue.

You see, Mr. Chairman, the funds the Federal Government makes available to physician assistant programs go, in large part, to reducing the cost of education. By reducing or eliminating federal assistance, you put increasing pressure on programs to replace those lost federal funds through increased tuition.

The reduction of funds at the federal level is being exacerbated at the state level because of increasing budgetary pressures on state legislatures. Two states provide a good example of what is happening.

As you know, Texas and Nebraska both have outstanding physician assistant programs. These programs receive a considerable amount of money from their respective state legislatures. Due to the problems in both the farm and oil industry, it is apparent that the state will not be able to provide as much money for education as they have in the past.

Now, even though some may consider this a cyclical problem, it is symptomatic of what can happen to education at the state level. Thus, when you combine cutbacks at the federal level with cutbacks at the state level, you can see that serious problems could exist.

The Administration has suggested that the Federal Government should get out of the business of funding physician assistant education. And, to a certain degree, it is true that most programs do not need federal funds to survive. While the loss will be felt at the program level, the greatest impact will be at the patient care level.

As you know, physician assistants are generally not eligible for most federal higher education assistance programs. This means that the $4,800,000 authorized for physician assistant programs is the main source of money available to reduce the cost of physician assistant education to the student. Reductions in federal assistance will inevitably lead to higher tuition.

Physician Assistant students, like many other young people pursuing a career in a medical profession, find it necessary to borrow money to pay for their education. Higher tuition means they must borrow more money. Physician assistants are finding that the degree of indebtedness of physician assistant students when they graduate has a strong bearing on the type of practice they enter and the area of the country in which they locate.

As you know, physician assistants have traditionally gravitated to regions of the country that were deemed medically underserved. For this reason, you found a high percentage of physician assistants working in very small, very rural communities or in underserved urban areas. Programs are finding that physician assistant students still want to practice in medically underserved areas but are forced, because of their relatively high level of indebtedness, to seek other practice settings.

Now, this isn't true for all physician assistants, Mr. Chairman, and I would be remiss if I left you with the impression that physician assistants are leaving rural areas in droves. They are not, and I fully expect that a significant portion of the physician assistant population will always be found in medically underserved areas. But we do see a correlation and it is one we think Congress should be aware of.

Another example of how cutbacks in federal funding will affect physician assistants is in the area of educational experiences. The on site geriatric learning experiences provided to students is similar to rotations occurring in medically underserved areas. One can only expect a reduction on funds to have an impact on the frequency and availability of these rotations. Furthermore, the lack of federal funds will force programs to raise tuition and fees in an effort to perpetuate congressionally mandated rotations in home health care, geriatrics, health promotion/disease prevention and other areas.

The reduction of funds available to support physician assistant education and thus student rotations in underserved areas could further amplify the correlation between indebtedness and job selection.

The $4,800,000 authorized for physician assistant education is not a great deal of money in the total scheme of the federal budget. But for physician assistants and health care delivery, it means a great deal.

We consider $4,800,000 a bare bones appropriation. It will allow programs to continue offering quality education at a relatively reasonable cost. Any less, and you will begin to see serious consequences for educational opportunities for physician assistants and the future of health care delivery.

I would also like to note, Mr. Chairman, that as part of the reauthorization signed by the President, physician assistant programs are now required to offer courses in geriatric medicine as a condition of receiving federal assistance. This is a requirement that the programs welcome and feel is quite necessary. Indeed, programs are already initiating educational experiences in this area.

We strongly urge the committee to appropriate the full $4,800,000 authorized and we look forward to working with you on this goal.

The academy appreciates the opportunity to present its views and I would be happy to answer any questions you might have.

Thank you very much, Mr. Combs. We want to thank you for your appearance before our committee. You have made an excellent statement.

What about it, Mr. May, would you like to make a statement?

Mr. MAY. I think the cutbacks will severely affect our efforts in the academy in trying to recruit more minorities to the physician assistant profession and I hope that that doesn't occur, and we hope that the Congress fully appropriates the $4,800,000.

Mr. NATCHER. Gentlemen, thank you very much. We appreciate your appearance before the committee. You have made excellent statements.

Mr. MAY. Thank you.

MONDAY, APRIL 28, 1986.

NINCDS

WITNESS

DIANA J. PILLAS, MEMBER, BOARD OF DIRECTORS, EPILEPSY FOUNDATION OF AMERICA

Mr. NATCHER. Our next witness is Ms. Diana Pillas. Come around, Ms. Pillas. We would be pleased to hear from you.

Ms. PILLAS. Good afternoon. My name is Diana Pillas, and I am a member of the Board of the Epilepsy Foundation of America. In addition to serving as President of the Epilepsy Association of Maryland, I am part of the clinical care team of the Epilepsy Center at Johns Hopkins Hospital.

On behalf of the Epilepsy Foundation, I would like to express appreciation for this opportunity to appear before the subcommittee today.

While many of the 2,000,000 Americans who have epilepsy are able to lead virtually normal lives, successful medical treatment still eludes many. There remain 600,000 people with only partial relief from seizures and 400,000 with virtually no relief. These statistics, however accurate, fail to convey the real dimension of the problems encountered by the individual whose seizure disorder has yet to be controlled and who is rejected by a society which fears what it does not understand.

The President's budget request would enable NINCDS to award 538 new and competing grants—107 or 17 percent fewer than the FY 86 appropriation level.

If equivalent reductions, as proposed for fiscal year 1987, had been enacted during FY 85, $42,800,000 would not have been awarded in the following specific areas: epilepsy, 6; stroke, 6; multiple sclerosis, 6; spinal cord and head injuries, 8; Parkinson's, 5; basic neurosciences, 29; communicative disorders, 35; and 26 in other neurological disorders.

EFA believes clinical research in epilepsy and many other disorders remains severely underfunded. Dr. Goldstein testified during last year's hearing that:

> It is that area of clinical research, dealing with the epileptic animal model or the epileptic human, which in the competition for available funds on a scientific merit basis does not receive the highest grades. This is true because these are the most difficult experiments to do, as opposed to the test tube experiment.

Clinical research funding increased 29 percent between '84 and '86 compared to 39 percent for basic research. This gap is only likely to widen as competition for funding grows more intense.

The Epilepsy Foundation is particularly concerned with the declining use of contract funding to support clinical research initiatives. The fiscal year 1987 request of $11,500,000 is 32 percent less than the $14,200,000 appropriated in fiscal year 1984.

Contract funds are used by the Epilepsy Branch of NINCDS to support the anti-epilepsy drug development program. Over the past decade, the Epilepsy Branch has evaluated and supported clinical research which ultimately led to FDA approval of four new drugs.

Epilepsy is a complex condition comprising more than 20 distinct seizure types. Although more than a dozen drugs are available to treat epilepsy, most produce side effects which can impair an individual's normal abilities. In order to improve the lives of these individuals who pay a high price for seizure control, new and approved anticonvulsants must be discovered.

The Epilepsy Foundation is alarmed by Dr. Goldstein's response to a question asked during this year's hearing by Congressman Early. Dr. Goldstein stated he would consider terminating the anti-epilepsy drug development program as well as the neuroprosthesis program if contract funding continues to decline.

The foundation has used this occasion in recent years to express our continuing concern with the declining share of the research budget of NINCDS which is allocated to epilepsy research. Total NINCDS funding increased by 124 percent between 1978 and 1985 compared to a 58 percent increase for epilepsy research. Adjusting for inflation, epilepsy research funding increased less than one percent while the NINCDS budget increased 42 percent since 1978.

Dr. Goldstein explained to this subcommittee last year that, "in order to make a meaningful breakthrough in the amount of support in a field like epilepsy, in addition to the fact that we need more and better trained investigators, we would have to increase the quantity of our support going into clinical research."

Yet we have already noted that NINCDS funding of clinical research, comprehensive centers and research and development contracts have steadily declined.

Congress must begin to address the underlying problem presented by the difficulty comprehensive centers or program projects have in securing funds. Congress and National Institutes of Health must find a new mechanism to evaluate clinical research grants so that clinical applications do not compete directly against basic grant applications.

Epilepsy is a prime example of a medical condition in which the individual and family members incur repeated direct and indirect costs.

NINCDS accomplishments have enabled countless individuals with neurological conditions to lead productive, independent lives. In order to continue this progress, the appropriation for NINCDS must be increased. The Administration's budget request of $399,000,000 is both unwise and unacceptable.

The Epilepsy Foundation of America, joins with the Consortium of Citizens with Developmental Disabilities in recommending the fiscal year 1987 appropriation of at least $505,000,000. This amount would enable NINCDS to maintain its programs at approximately the 1985 level.

[The statement of Ms. Pillas follows:]

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MEMBER NATIONAL HEALTH COUNCIL

STATEMENT RESPECTFULLY SUBMITTED

TO THE

SUBCOMMITTEE ON LABOR, HEALTH AND

HUMAN SERVICES, AND EDUCATION

OF THE

HOUSE APPROPRIATIONS COMMITTEE

BY

DIANA J. PILLAS

ON

THE FISCAL YEAR 1987 APPROPRIATION FOR THE

THE NATIONAL INSTITUTE FOR NEUROLOGICAL AND COMMUNICATIVE

DISORDERS AND STROKE (NINCDS)

ON BEHALF OF THE

EPILEPSY FOUNDATION OF AMERICA

APRIL 28, 1986

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Epilepsy—The more you know about it, the more you want to help.

Mr. Chairman:

Good afternoon. My name is Diana Pillas, and I am on the Board of Directors of the Epilepsy Foundation of America. I also serve as President of the Epilepsy Association of Maryland.

On behalf of the Epilepsy Foundation, I would like to express appreciation for this opportunity to appear before the Subcommittee today.

While epilepsy is the second most prevalent neurological disorder - affecting over 2 million Americans, or one out of every 100 persons, it remains one of the most misunderstood health conditions in America today.

While there have been significant medical advances in the understanding and treatment of epilepsy during the past decade, half of those with epilepsy still cannot gain full control of their seizures. Normal one minute, out of control the next; children and adults with epilepsy are disabled not only by the unpredictable and devastating character of the disorder, but also by the constant misunderstanding and rejection by a society which fears what it does not understand.

In its 1977 Report to the Congress and the President, the National Commission for the Control of Epilepsy and its Consequences, found that every person affected by epilepsy experiences social, psychological and behavioral problems in degrees ranging from coping with and adjusting to the daily fears and uncertanties associated with epilepsy, to more severe problems which create effective barriers to social adjustment, to obvious psychiatric disorders.

While many of the 2 million Americans who have epilepsy are able to lead virtually normal, productive lives because of effective diagnosis and treatment methods, successful medical treatment still eludes many. There remain some 600,000 people with only partial relief from seizures, and 400,000 with virtually no relief.

These statistics, however accurate, fail to convey the real dimension of the problems encountered by the individual whose seizure disorder has yet to be controlled through medication.

This Subcommittee has heard testimony from officials of the National Institutes of Health (NIH), including Dr. Murray Goldstein, Director of the National Institute for Neurological Disorders and Stroke (NINCDS), regarding current research opportunities and the program curtailments which would result if the President's budget requests for FY 1987 were enacted.

The Administration's budget request of $399.351 million for NINCDS would not only have a deleterious effect upon biomedical research, but more importantly, upon the quality of life experienced by millions of Americans well into the future.

This afternoon, The Epilepsy Foundation would like to comment on each of the following components of the Administration's budget request for NINCDS:

o the proposed 17 percent reduction in the number of new and competing research grants;

o the significant reduction in the number of clinical trials which would be initiated;

- o the proposed 19 percent reduction of contract funding from the FY 1985 level of funding;
- o the trend within NINCDS to protect basic research at the expense of clinical research, research centers and contract funding; and
- o our continuing concern over the disproportionate share of epilepsy research funding compared to funding for less prevalent disorders.

New and Competing Grants

The President's budget request would enable NINCDS to award 538 new and competing grants - 107 or 17 percent fewer than the FY 1986 appropriation level. Since the proposed funding level of $80.126 million is 24 percent less than the FY 1986 appropriation, the award amount for each grant will be subject to significant reductions.

In 1985, the actual priority score payline for NINCDS was 157 and its award rate was 38 percent. The automatic payline for the current fiscal year is 140 - although it is expected to rise to 150 after grants of high program relevance are awarded later in the year. The anticipated overall award rate is 27 percent. If the President's 1987 request was enacted, the overall payline would drop to 140 and the award rate to 22.5 percent.

If equivalent reductions, as proposed for FY 1987, had been enacted during FY 1985, the most recent year for which data is available, then the 1985 priority score payline of 157 would have dropped to 149. The funding rate would have dropped from 38 percent to 29 percent. Applying this reduced payline to grants actually awarded during 1985, we found 121 grants totalling $42.8 million would not have been awarded in the following specific areas:

Disorder	(millions) Amount	Number of actual FY 1985 grants that would not have been awarded
Epilepsy	$3,166	6
Stroke-Cerebrovascular	$3,084	6
Multiple Sclerosis	$2,894	6
Spinal cord and head	$2,811	8
Parkinson's	$2,171	5
Basic neurosciences	$7,949	29
Hearing, speech, language	$10,035	35
Other neurological disorders	$10,655	26

The Epilepsy Foundation urges the Subcommittee to provide funding sufficient to enable NINCDS to award and fully fund the same number of grants as it did during fiscal year 1985.

CLINICAL RESEARCH

EFA believes clinical research in epilepsy and many other disorders remains severely underfunded. Dr. Goldstein testified during last year's hearing that:

> "In order to make a meaningful breakthrough in the amount of support in a field like epilepsy, which is heavily based on clinical science as differentiated from basic science at the cell biologic level, it means that we must have a team of clinical investigators working with epileptic patients... It is that area of clinical research, dealing with the epileptic animal model or the epileptic human, which in the competition for available funds on a scientific merit basis does not receive the highest grades. This is true because these are the most difficult experiments to do, as opposed to a test tube experiment".

This fact is documented in the budget justification. Clinical research funding increased 29 percent between 1984 and 1986 compared to 39 percent for basic research. This gap between funding of basic and clinical research is only likely to widen as competition for available funding grows more intense.

Research and Development Contracts

The contract mechanism is often used to support high priority clinical research. This, unfortunately, is not the case within NINCDS today.

The use of contract funding by NINCDS has steadily declined in recent years. The fiscal year 1987 request of $11.5 million is 32 percent less than the $15.2 million appropriated in fiscal year 1984. As a percent of the total NINCDS budget, contract funds have declined from 4.5 percent in 1984 to 2.9 percent in the 1987 budget request. The overall NIH average, in comparison, would be 6.8 percent even under the Administration's request.

The Epilepsy Foundation is particularly concerned with the declining use of contract funding to support clinical research initiatives.

Contract funds are used by the Epilepsy Branch of NINCDS to support the Antiepileptic Drug Development (ADD) program. Over the past decade, the Epilepsy Branch has evaluated and supported clinical research which ultimately led to FDA approval of four new drugs.

Epilepsy is a complex condition comprising more than 20 distinct seizure types. While substantial progress has been made in controlling some of these forms of epilepsy, many remain resistant to current therapy. Facts show that 50 percent of all people with epilepsy continue to suffer from occasional seizures, and over 200,000 people experience more than one seizure each month.

Although more than a dozen drugs are available to treat epilepsy, most produce side effects which can impair an individual's normal abilities. For example, prolonged use of phenobarbital can result in slower physical and mental reflexes, which with continued use may lead to impaired mental functioning. Children and adults with epilepsy, sometimes become so sedated by the drugs they must take to achieve seizure control that ultimately they cannot function normally in school or on the job.

In order to improve the lives of these individuals who pay a high price for seizure control, new and approved anti-convulsants must be discovered.

Dr. Goldstein, in response to a question asked during this year's hearing by Congressman Early, stated he would consider terminating the Antiepileptic Drug Development program as well as the Neuroprosthesis program if contract funding continues to decline. The Epilepsy Foundation views this possibility with great alarm.

Clinical Trials

A similar crisis confronts all of NIH. The President's budget proposes initiating only 9 major clinical trials during fiscal year 1987 compared to the 44 funded by this year's appropriation.

In response to a question asked by Senator Weicker during this year's hearing, Dr. Goldstein explained that the President's budget request would not enable NINCDS to initiate any major clinical trials next year.

There are several promising anti-convulsant compounds which are ready for clinicial testing during fiscal 1987. The President's proposal to not initiate any new clinical trials is simply inexcusable.

Comprehensive/Specialized Research Centers

The importance and contributions of multidisciplinary research centers in neurological research areas has long been documented. The Epilepsy Foundation recognizes the need to balance support between basic neurological research and more targeted basic and clinical research. We do not, however, believe such a balance exists today in epilepsy.

While the Administration's $26.4 million request for research centers represents a 12.5 percent reduction from the fiscal year 1986 appropriation, NINCDS plans to continue supporting 38 centers. The requested funds will require negotiated reductions of approximately 14 percent according to the 1987 Justification Document.

EFA believes there remains a strong need today for an expanded multidisciplinary approach to epilepsy research. High quality, state of the art clinical research is needed. Effective methods of technology transfer between the laboratory and the practicing physician are needed. And there is an urgent requirement to train the clinician scientists of tomorrow if the momentum of epilepsy research is to be sustained.

The Epilepsy Foundation urges the Subcommittee to provide sufficient funding to enable NINCDS to fully support at least 40 research centers - the same number as supported during 1985.

Epilepsy Research Trends

The Foundation has used this occasion in recent years to express our growing concern with the declining share of the research budget of the National Institute for Neurological and Communicative Disorders and Stroke (NINCDS) which is allocated to epilepsy research. This problem continues as Dr. Goldstein pointed out to members of the House Subcommittee earlier this year.

Total NINCDS funding increased by 124 percent between 1978 and 1985 compared to a 58 percent increase for epilepsy research. Adjusting for inflation, epilepsy research funding increased less than 1 percent while the NINCDS budget increased 42 percent since 1978.

There can be no question that the epilepsy research field is ripe for further development. New antiepileptic drugs are awaiting the clinical testing phase. Side effects of existing drugs are being recognized. The potential of MRI, PET, MEG and other imaging techniques is very promising both in basic and clinical research. There is exciting new work being done in genetics that has the potential for application to epilepsy, especially at the molecular level. New applications of surgical techniques offer the possibility of therapeutic advances.

Yet Dr. Goldstein explained to this Subcommittee last year that, "In order to make a meaningful breakthrough in the amount of support in a field like epilepsy, in addition to the fact that we need more and better trained investigators, we would have to increase the quantity of our support going into clinical research".

Yet we have already noted that NINCDS funding of clinical research, comprehensive centers and research and development contracts have steadily declined.

Many of the most important and successful advances in epilepsy research, diagnosis and treatment have come about because of the six Comprehensive Epilepsy Programs which were funded through the use of the contract mechanism during the seventies.

This year, for instance, the University of Minnesota's Comprehensive Epilepsy Program - one of the original six CEP's - faces the lost of its research funding on July 1. Why? Because its priority score of 147 is slightly above the existing automatic payline of 140. Yet this multidisciplinary program project is considered one of the best centers in the nation. Its priority score is excellent for a major program project which has a significant clinical base.

Congress and NIH must find a new mechanism to evaluate clinical research grants so that clinical applications do not compete directly against basic grant applications. In doing so, Congress would begin to address the underlying problem presented by the funding situation faced by this center and other comprehensive centers or program projects.

Conclusion

Epilepsy is a prime example of a medical condition in which the individual and family members incur repeated direct and indirect costs. Many of the direct costs are easily identified -- medical costs including physician care, medication, hospitalization, the treatment needs of the severely disabled for continuous or residential care, as well as costs for special education, research, vocational rehabilitation and increased insurance rates. Indirect costs result not only from the inability to work, but frequently from a reduced period of productivity due to a shortened life span.

While some persons with epilepsy and their families are able to shoulder this burden themselves, society absorbs much of the cost in order to sustain and support individuals who have not been able to attain economic independence due to the seriousness of their condition or because of societal attitudes toward them.

NINCDS accomplishments have enabled countless individuals to lead productive, independent lives. In order to continue this progress, the appropriation for NINCDS must be increased. The Administration's budget request of $399 million is both unwise and unacceptable.

The Epilepsy Foundation of America, joins with the Consortium for Citizens with Developmental Disabilities, in recommending a fiscal 1987 appropriation of at least $505 million. This amount would enable NINCDS to maintain its programs at approximately the same level as intended by the 1985 appropriation.

Mr. NATCHER. Thank you very much, Ms. Pillas.

You made an excellent statement, and we appreciate your appearance before the committee.

MONDAY, APRIL 28, 1986.

AIDS RESEARCH

WITNESS

JEFFREY LEVI, DIRECTOR, GOVERNMENT AND POLITICAL AFFAIRS, NATIONAL GAY TASK FORCE

Mr. NATCHER. Our last witness this afternoon is Mr. Jeffrey Levi.

Come around, we will be pleased to hear from you at this time.

Mr. LEVI. Thank you, Mr. Chairman.

I am testifying on behalf of the National Gay and Lesbian Task Force, the oldest national gay/lesbian civil rights advocacy organization. Since the beginning of the AIDS crisis, we have been privileged to work with you and this committee to help solve this terrible medical mystery and assure adequate education, treatment and services for those affected by AIDS.

Your leadership has been essential to the tremendous progress we have made to date, especially in light of the Administration's consistent resistance to providing adequate funding for this struggle.

We cannot allow our concern about AIDS to diminish. The number of AIDS cases continues to rise at an alarming rate. When I testified before this committee last year, there were 10,000 cases. This week, we crossed the 20,000 mark.

We are only beginning to recognize the needs of those millions who have AIDS-related conditions or are infected with HTLV-III.

We are also witnessing the nationalization of the disease; it is no longer concentrated in a few geographic areas. More and more communities must be assisted in coping with this public health crisis.

As I travel across the country, I find that we are unfortunately moving to a two-class system of access to care and services for persons with AIDS. Those living in high-incidence communities have access to research protocols and model care facilities, while elsewhere increasing numbers of persons with AIDS are relegated to levels of care that are months or years behind our medical knowledge and capabilities.

There can be no doubt about the tremendous scientific progress that has been made during this crisis. But with each advance, more and more avenues are opened for additional exploration.

For example, as a drug moves through the various stages of trials, the number of individuals involves in those trials increases. Thus, each advance in finding a potential drug therapy requires additional resources.

This makes all the more cynical the Administration's proposal for recisions totaling $41,000,000 over the Gramm-Rudman-Hollings cuts. We commend the Congress for rejecting this move, as it would have crippled some of the critical components of the fight against

AIDS: Cutting basic research at NIH, eliminating demonstration health care programs, and abolishing alternative testing sites at a time when the Public Health Service is calling for increased HTLV-III antibody testing.

We believe a significant increase in PHS AIDS funding for fiscal year 1987 beyond the $244,000,000 appropriated in 1986 will be essential to maintain the level of progress we are making, and to meet our responsibility to provide for those who become ill.

There is a range of areas that require additional attention. These include:

Expanded education programs to teach individuals in high-risk groups how to prevent transmission of the HTLV-III virus and to train health care professionals how to treat and counsel those affected by the disease.

The focus of their efforts must be broader than in the past, to include, in particular, adolescents, IV drug users, and those in low-incidence communities where awareness about AIDS may still be low. This money would be well invested; if prevention activities saved 2,600 individuals from developing AIDS, we would save $400,000,000 in health care costs alone.

We also need expanded clinical trials of therapeutic drugs to assure that the entire range and combinations of anti-virals and immune stimulators are fully explored and to assure greater access to these trials for persons with AIDS.

Congress should expand the non-hospital-care demonstration projects to low- and middle-range incidence communities. $16,000,000 was first approved this year for high-incidence localities.

If such demonstration programs can reduce the cost of care as dramatically as San Francisco's model has, where the cost of care averages $35,000 instead of the national average of $140,000, then the savings in the Federal share of medicaid costs alone would pay for such programs many times over.

Research into the epidemiology and natural history of AIDS related conditions, ARC, is essential to gain a better understanding of the course of the HTLV-III infection and what can be done to care for and possibly halt the progress of the disease.

We do not fully understand the scope of the ARC problem. While not a fatal condition, ARC is chronic and its impact on the lives of those affected and the associated burden on the health care system are issues that must be addressed.

In addition to providing adequate funds for the AIDS budget, it will be essential to restore funds to those parts of the CDC and NIH budgets that have been diverted from other activities to meet the AIDS emergency. One of the more self-defeating diversions has been from sexually-transmitted disease prevention at CDC.

We are told that between 15 and 30 percent of the 1986 STD budget has been spent on AIDS. This has contributed to a continued growth in certain sexually-transmitted diseases, including many that are fatal.

It also has denied health educators an opportunity to reach those who do not perceive themselves to be at risk for AIDS with a prevention message, one that would also protect them from infection with HTLV-III.

This is just a sampling of some of the additional work that needs to be done to address this crisis in the coming fiscal year. Figures proposed before the House Budget Committee have documented a need for between $390,000,000 and $400,000,000.

We think that such an amount would begin to meet the full range of needs this growing medical and social crisis will demand in the next fiscal year. We recognize that Congress faces ever-tightening fiscal constraints.

But the battle to save lives must continue. If waged effectively, this effort will save the Federal Government in direct medicaid costs now and in similar costs later as the progress of the disease is halted. Delay will be counted in lives and care costs that will be a tragedy for this Nation.

We hope we can count on your continuing leadership as our Nation faces this difficult challenge. We look forward to working with you through this new appropriations cycle to assure further progress against this disease.

Thank you, Mr. Chairman.

Mr. NATCHER. Mr. Levi, you have made an excellent statement. We appreciate your appearance before the committee.

At the end of the appropriation process for fiscal year 1986, we had $244,307,000 for AIDS programs. That included $9,955,000 that was appropriated for the food and drug administration which is handled by the Agriculture subcommittee that I serve on. We ended up after sequestration with $233,802,000; and the request before the committee at this time for 1987 is $213,247,000.

I just wanted to get those figures in the record. This is a major health problem in this country, and we appreciate your appearance.

Mr. LEVI. Thank you very much.

Mr. NATCHER. This concludes the hearings for this afternoon, and the committee will now adjourn until 10:00 in the morning.

TUESDAY, APRIL 29, 1986.

TALENTED TEACHERS ACT

WITNESS

HON. RON WYDEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. NATCHER. Our first witness this morning is Ron Wyden of Oregon, and Mr. Wyden, it is a pleasure to have you before the committee, and we will be pleased to hear from you.

Mr. WYDEN. Thank you very much, Mr. Chairman.

Let me just thank you for your tremendous patience and consideration with regard to the Talented Teachers Program.

During this time of significant budget cuts, it is always hard to look at a new approach, and I just want you to know, Mr. Chairman, that I think you have given a disproportionate amount of your time, patience, and interest in working with me and other members that are interested in this subject.

I want you to know that I am very, very appreciative of all the consideration I have been given in the past, and look forward to working with you in the future as well.

Mr. NATCHER. Mr. Wyden, we want to thank you for your statement. All of us on the subcommittee have enjoyed working with you. Last year, as you and I well know, you were out in the lead as far as this program is concerned, and you did a good job, and it is a pleasure for us to join with you.

Mr. WYDEN. Mr. Chairman, I have a couple of quick comments, and with your indulgence, perhaps my full remarks could be put in the record.

[The statement of Mr. Wyden follows:]

TESTIMONY

OF

CONGRESSMAN RON WYDEN

BEFORE THE

SUBCOMMITTEE ON LABOR -- HEALTH AND HUMAN SERVICES -- EDUCATION

OF THE

HOUSE COMMITTEE ON APPROPRIATIONS

APRIL 29, 1986

Good morning and thank you for allowing me to come here to discuss funding for the Talented Teacher Act of 1983 (Public Law 98-558).

Mr. Chairman, The Talented Teacher Act provides scholarships to the brightest students in our high schools who agree to go into the teaching profession -- and fellowships for outstanding teachers now in the classroom, to advance themselves professionally.

Although this is still a program in the making, calls and letters from interested students, teachers and state education departments already have been pouring into my office. With the interest level in this very new program this high, I think it's quite possible that we're witnessing a success story in the making. I'm sure that once this legacy of our well-remembered colleague, Carl Perkins, is fully funded and available to bright students and teachers it will provide a new direction for our nation's educational system.

With the Talented Teacher Act, Congress can add a new focus to the federal role in education: excellence. Traditionally, the federal government has focused on access and equity with regard to education. With a funded Talented Teacher Act, we can make a clear statement that now is the time to create new incentives so that we can enlist some of the most talented to teach our young.

We've had innumerable commissions and blue ribbon task forces that have all reached one conclusion: our educational system lacks the magnets to attract excellence to this critical area.

The Talented Teacher Act was one of the first major legislative efforts to directly address these recommendations. Now is the time to put this program to work.

Three years ago, I worked with our colleague, then Congressman and now Senator Simon, and several others on the Merit Pay Task Force. The purpose of the task force was to develop legislation to improve our nation's educational system by encouraging bright young people to choose careers in teaching, and by recognizing the abilities of teachers already in the profession.

Later that year, Chairman Simon, Congressman Bill Goodling, Congressman Thomas Coleman and I introduced the Talented Teacher Act of 1983.

The act, which was signed into law last year, sets up a four-year experimental program which will provide up to $5,000 a year in scholarships for the best and brightest high school graduates to attract them to the teaching profession. The students will be required to teach for two years for each year they received this college scholarship.

The act also provides fellowships for outstanding teachers to take a one-year sabbatical for study and further development of their teaching skills. One teacher in each Congressional district will be singled out for his or her contributions to education. After the year, the teachers will return to their school districts to share the knowledge they've gained with their students and colleagues.

The Talented Teacher Act is an important, modestly priced first step in the effort to achieve the goal of excellence in American education. The price tag is $96 million over four years, for both the fellowship and scholarship programs.

The scholarship portion of this program has received an appropriation of $10 million. I have been informed by the Department of Education that the regulations for distributing these funds to the states are near completion, and will be ready by May 1st of this year. We hope to have the scholarship program ready for this year's high school graduates.

The authorization is as follows: For the scholarship program, for FY '86, $20 million; for FY '87, $21 million; for FY '88, $22 million; for FY '89, $23 million. For the fellowship program the following is authorized: for FY '86, $1 million; for FY '87, $2 million; for FY '88, $3 million; for FY '89, $4 million.

The fellowship component of this program was recently renamed the Christa McAuliff Talented Teachers Fellowships. This fellowship can be a fitting tribute to this courageous teacher who lost her life in the Space Shuttle Challenger tragedy. By funding this program, we can be sure that the best and brightest teachers of this country will have a clear signal that something is getting done to improve our educational system.

Ensuring that America will have the best educational system in the world for years to come is an enormous task. But by encouraging top students to enter teaching and top teachers to stay there, the Talented Teacher Act will move us further down that path. As such, I believe it should be a priority for funding by this body.

Thank you and I'll be happy to answer any questions you may have.

Mr. WYDEN. It seems to me, Mr. Chairman, that one way or another, this country has got to figure out a way to get some of the best and the brightest to go into teaching.

You can go into almost any high school classroom in this country, and when you talk to the high school seniors, they want to be doctors, lawyers or engineers, or go into business, just about anything except teaching.

What this bill is all about is to try to figure out a way, in a modest kind of initiative, to turn that around, and it sets in place a special scholarship and fellowship program to try to bring some new prestige and some new recognition to people who are going into teaching.

What I hope can be done out of this is that the Federal Government, set up a model for scholarships for bright young people going into teaching and a fellowship for teachers already in the field. The Christa McAuliffe Fellowship Program has been renamed by the House. I hope that these two programs would serve as models for the States, and community service organizations, and various foundations, to copy.

There is no question that with the modest appropriations that are being requested here, we can't magically bring the thousands of gifted teachers into the profession that this country needs.

What we can do is set up a good model, Mr. Chairman, I think something like this dovetails well with the kind of approach that we can look at in the human services, and education during the time of Gramm-Rudman.

We cannot come before you, Mr. Chairman, and say that the purse is unlimited and ask for billions and billions of dollars. In fact, this approach takes a step away from that outlook and with a small appropriation, can accomplish a lot of good, and do something worthwhile that would be established around the country.

This program, in a sense, is very much like an educational ROTC. We give scholarships to bright young people. They have to go into the teaching field as a result. There are stiff penalty provisions, if they don't meet their obligation. It also resembles a program that has worked well around the country, and would be administered at the State level.

The regulations should be out in the next few days, so we will be able to start sending young people to college with these scholarships in the fall of 1986. Mr. Chairman, perhaps I ought to break off my orating and again tell you I am very, very appreciative and I know that many people come before you, and you have many demands on your time, but you have given me more than my fair share of your time, and I am very grateful.

Mr. NATCHER. We want to thank you for your appearance. You made an excellent statement.

TUESDAY, APRIL 29, 1986.

HEALTH ISSUES

WITNESS

STEPHEN LAWTON, COALITION FOR HEALTH FUNDING

Mr. NATCHER. Our next witness is Mr. Stephen Lawton. Come around, Mr. Lawton.

We are glad to have you back before the committee, and we will be pleased to hear from you.

Mr. LAWTON. I want to say to you personally, on behalf of the public health community, that you are not only one of the most effective, but one of the most polite Members of Congress that we ever deal with, and we always feel better having visited with you, and we just appreciate the time and the attention that you give to us, and the manner in which you do it.

I am a Washington lawyer, and I represent the Coalition for Health Funding, which is composed of over 40,000 national health organizations that represent voluntary health agencies, consumers and providers of health services, the institutions that train health professions and others.

Our membership includes the American Academy of Pediatrics and its concern over child immunization programs, Infectious Disease Society and its concern over AIDS and other programs, the Schools of Public Health and others.

The thread that unites these diverse groups is an overriding concern for the Public Health Service's research, service, and training programs, which each of you has supported so well over the years.

The Coalition is deeply concerned about the impact the Balanced Budget and Emergency Deficit Control Act, more commonly known as Gramm-Rudman, has had and will have on discretionary health programs.

As you well know, Gramm-Rudman has initiated a process euphemistically called sequestration.

On February 1, 1986, the President issued a sequestration order which became effective on March 1, 1986. The order mandated 4.3 percent cuts in funding for virtually all of the discretionary health programs, with the exception of the Community and Migrant Health Centers programs, which sustained a 1-percent cut.

Perhaps a 4.3-percent funding reduction does not sound like very much, but as a direct result of that sequestration, the following has occurred:

$236,000,000 in funding for the National Institutes of Health research support was eliminated, necessitating across-the-board funding cuts in all ongoing research and training programs, irrespective of need or merit.

Over $10,000,000 in funding for AIDS research was cut at a time when scientists are coming closer to identifying a vaccine that can prevent this fatal disease.

424 training grants that were to be awarded to young researchers by the NIH were eliminated.

Funding sufficient to allow 65,000 children to receive immunizations against childhood diseases was deleted.

35 grants of regional and national significance were cut from the Maternal and Child Health Program.

Funds to allow the Community Health Centers program to expand health services in 10 rural communities for an additional 50,000 people were lost.

18 health professions scholarships for students in exceptional financial need were never awarded.

And planned traineeship positions for 252 public health and 100 nursing students were abandoned.

Mr. Chairman, these cuts I have just described, and many like them that time will not permit me to detail, had a profound impact on our Nation's biomedical research effort, the health of our children and various health professions training programs designed to assure the continued availability of the most highly qualified nurses, physicians, dentists, public health workers and the like.

Perhaps the most disturbing aspect of the Gramm-Rudman inspired cuts was their indiscriminate nature. Each program funded under the auspices of the PHS is unique, be it family planning or immunizations grants.

And it used to be exclusively within the purview of this committee to gauge the essential financial requirements of each PHS program and to fund them accordingly, based on extensive and exacting hearings, and substantive and effective staff work by Henry Neal and by Mike Stephens and by others.

Gramm-Rudman, however, effectively reduces the studied recommendations of this committee to rhetoric because of its power to virtually obliterate committee judgments by means of a mindless, unfeeling, unthinking, bloodless formula: A result which has the very real potential to undo much of progress in health care and research assiduously fostered by this committee.

Public Health Service programs save health care costs because they save medical care dollars, and this has been demonstrated by the Institute of Medicine as recently as a year ago, in its Study of the Impact of Vaccines on ultimate health care costs.

As you may know, the Coalition submitted an amicus curiae brief in the Gramm-Rudman case, which was argued before the U.S. Supreme Court on April 23, 1986. In its brief, the Coalition asked that the Supreme Court affirm the decision of the lower court that the automatic sequestration process is unconstitutional as a violation of the principles of separation of powers.

I will submit the brief for the record, because we detail the impact of the 4.3-percent cut. I would ask unanimous consent that it be made a part of the record at this point.

[The information follows:]

Nos. 85-1377, 85-1378, 85-1379

IN THE
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OCTOBER TERM, 1985

CHARLES A. BOWSHER,
COMPTROLLER GENERAL OF THE UNITED STATES,
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v.
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Appellees.

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Appellees.

On Appeal from the United States District Court for the District of Columbia

BRIEF FOR *AMICI CURIAE* COALITION FOR HEALTH FUNDING, *ET AL.*

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[Complete list of *Amici* on inside cover]

AMICI CURIAE

American Council on Education

American Hospital Association

Coalition for Health Funding on behalf of:

- American Academy of Pediatrics
- American Association of Colleges of Nursing
- American Association of Colleges of Pharmacy
- American Association of Colleges of Podiatric Medicine
- American Association for Dental Research
- American Association of Dental Schools
- American Heart Association
- American Lung Association
- American Nurses Association
- American Public Health Association
- Association of American Veterinary Medical Colleges
- Association of Schools of Public Health
- Association of University Programs in Health Administration
- Cystic Fibrosis Foundation
- Infectious Diseases Society of America
- March of Dimes Birth Defects Foundation
- National Association of Children's Hospitals and Related Institutions
- National Family Planning and Reproductive Health Association
- National League for Nursing
- Planned Parenthood Federation of America

Juvenile Diabetes Foundation International

National School Boards Association

Western Association of Children's Hospitals

QUESTION PRESENTED

Whether the district court properly ruled that, because the automatic deficit reduction procedures of the Balanced Budget and Emergency Deficit Control Act are unconstitutional, the President's sequestration order issued pursuant to those procedures is "without legal force and effect," thereby requiring the restoration of all wrongfully cancelled funds?

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Arizona Governing Committee for Tax Deferred Annuity and Deferred Compensation Plans v. Norris, 463 U.S. 1073 (1982) ... 9, 17
Brown v. Board of Education, 349 U.S. 294 (1955) ... 16
Buckley v. Valeo, 424 U.S. 1 (1975) ... 11-12, 13
Cash v. Califano, 621 F.2d 626 (4th Cir. 1980) ... 9, 10, 14, 19
Chevron Oil Co. v. Huson, 404 U.S. 97 (1971) ... *passim*
Chicot County Drainage District v. Baxter State Bank, 308 U.S. 371 (1940) ... 9
Cipriano v. City of Houma, 395 U.S. 701 (1969) ... 10, 16, 17
City of Los Angeles Dept. of Water and Power v. Manhart, 435 U.S. 702 (1978) ... 9, 10, 17
City of Phoenix v. Kolodziejski, 399 U.S. 204 (1970) ... 10
Cochran v. Birkel, 651 F.2d 1219 (6th Cir. 1981), *cert. denied*, 454 U.S. 1152 (1982) ... 9-10
England v. Louisiana State Board of Medical Examiners, 375 U.S. 411 (1964) ... 10
International Union, United Automobile, Aerospace and Agricultural Implement Workers of America v. Donovan, 570 F. Supp. 210 (D.D.C. 1983) ... 16
INS v. Chadha, 462 U.S. 919 (1983) ... 11, 15
Kendall v. United States ex. rel. Stokes, 37 U.S. 523 (1838) ... 15
Kennedy v. Mathews, 413 F. Supp. 1240 (D.D.C. 1976) ... 16
Lemon v. Kurtzman, 411 U.S. 192 (1973) ... 10, 14, 16
Linkletter v. Walker, 381 U.S. 618 (1965) ... 8
National Ass'n of Broadcasters v. FCC, 554 F.2d 118 (D.C. Cir. 1976) ... 13-14
National Council of Community Health Centers, Inc. v. Weinberger, 361 F. Supp. 897 (D.D.C. 1973) ... 15
Northern Pipeline Construction Co. v. Marathon Oil Co., 458 U.S. 50 (1981) ... 9, 10

TABLE OF AUTHORITIES—Continued

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Norton v. Shelby County, 118 U.S. 425 (1886) 8
Schaefer v. First National Bank, 509 F.2d 1287 (7th Cir. 1975), *cert. denied*, 425 U.S. 943 (1976) 14
State Highway Comm'n v. Volpe, 479 F.2d 1099 (8th Cir. 1973) 15
United States v. Johnson, 457 U.S. 537 (1982) 8-9, 14
Valencia v. Anderson Bros. Ford, 617 F.2d 1278 (7th Cir. 1980), *rev'd*, 452 U.S. 205 (1981) 14

Statutes:

Balanced Budget and Emergency Deficit Control Act of 1985, Pub. L. No. 99-177, 99 Stat. 1037 *et seq.* 2, 3
- Section 201 (a) (7) 3
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Department of Labor, Health and Human Services, Education and Related Agencies Appropriations, Act for Fiscal Year Ending September 30, 1986, Pub. L. No. 99-178, 99 Stat. 1102 (1985) 4
Further Continuing Appropriations Act of 1985, Pub. L. No. 99-190, 99 Stat. 1185 (1985) 4
Social Security Act of 1965, as amended, Pub. L. No. 89-97, 79 Stat. 291, Title XVIII (codified at 42 U.S.C. § 1395 *et seq.*) 4

Legislative and Regulatory Materials:

131 Cong. Rec. H9608-09 (daily ed. Nov. 1, 1985) 12
131 Cong. Rec. H11881 (daily ed. Dec. 11, 1985) 11-12
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131 Cong. Rec. H11891 (daily ed. Dec. 11, 1985) 11-12

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131 Cong. Rec. H11893-94 (daily ed. Dec. 11, 1985) 11-12
51 Fed. Reg. 1917 (1986) 3
51 Fed. Reg. 1927 (1986) 4
51 Fed. Reg. 1930 (1986) 3
51 Fed. Reg. 1932 (1986) 4
51 Fed. Reg. 1933 (1986) 4
51 Fed. Reg. 1934 (1986) 3, 4
51 Fed. Reg. 2813 (1986) 3
S. Doc. No. 24, 99th Cong., 2d Sess. (1986) 4, 18
21 Weekly Comp. Pres. Doc. 1490 (Dec. 12, 1985) 13

Miscellaneous:

The Committee for Education Funding, Budget Impact Alert, The President's Proposed Budget for Education and Its Impact for Fiscal Year 1986 (1986) 19
Hearings on the Federal Childhood Immunization Program Before the Subcommittee on Health and Environment of the House Committee on Energy and Commerce (Mar. 10, 1986) 18
U.S. Department of Health and Human Services, Health Care Financing Administration, Transmittal No. 86-2 (Feb. 1986) 17-18
U.S. Department of Health and Human Services, Health Care Financing Administration, Transmittal No. LM86-1 (Feb. 1986) 17-18
U.S. Department of Health and Human Services, Report on Sequestration Under the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings) for Committee on Appropriations 1986 (1986) 17, 18

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**On Appeal from the United States District Court
for the District of Columbia**

BRIEF FOR *AMICI CURIAE* COALITION FOR HEALTH FUNDING, *ET AL.*

The Coalition for Health Funding (the "Coalition") *et al.* submits this brief *amici curiae* on behalf of twenty-five organizations representing health and education interests in support of Appellees Mike Synar, Member of Congress, *et al.* It is accompanied by the written consents of Appellants and Appellees.

INTEREST OF *AMICI CURIAE*

The Coalition for Health Funding is a nonprofit coalition of health organizations devoted to promoting and monitoring the funding of health care programs. The Coalition is joined in this brief *amici curiae* by several health and educational associations which share a similar interest in promoting funding for health and educational programs. (A list of *amici* is set forth in the Appendix attached hereto.) These associations are involved with virtually all federally-funded health and education programs. They represent the educational institutions that administer federally-funded research, public health and education grants; the providers of federally-funded health services, such as hospitals, physicians, nurses and family planning clinics; the recipients of federal research grants, student trainees and program administrators; and the voluntary health organizations that are concerned with the federally-funded programs that impact upon the health of the American public.

The March 1, 1986 sequestration order mandated by the Balanced Budget and Emergency Deficit Control Act of 1985, Pub. L. No. 99-177, reduced duly enacted levels of support for most health and education programs by 4.3 percent, and reduced payments under the Medicare program by one percent. *Amici curiae* and their members were adversely impacted by these budget cuts, which forced significant curtailments in grants, traineeships and scholarships, reimbursement levels, contracts, and other health and educational services. Thus, these organizations have a direct interest in this Court's decision concerning the constitutionality of these budget reductions.

INTRODUCTION

A. The Deficit Control Act And Its Impact On Health And Education Programs

The Balanced Budget and Emergency Deficit Control Act of 1985 (the "Deficit Control Act" or "Act"), Pub. L. No. 99-177, 99 Stat. 1037 (1985), popularly known as the Gramm-Rudman Act, radically changes the federal budget process in an effort to achieve a balanced federal budget by the year 1991. In order to reach that goal, the Act imposes strict year-by-year deficit targets called "maximum deficit amounts", and adopts extraordinary new budget procedures. *See* Act §§ 201(a)(7), 251-257, J.A. 104, 109-161.

In accordance with these procedures, on January 15, 1986, the Congressional Budget Office ("CBO") and the Office of Management and Budget ("OMB") issued a joint report to the Comptroller General estimating the deficit for the 1986 fiscal year. Since they determined the deficit would exceed the designated maximum deficit amount, they calculated the requisite budget reductions for both nondefense and defense programs. The budget reductions amounted to 4.3 percent for most health and education programs, and one percent for Medicare. 51 Fed. Reg. 1917, 1930, 1934 (Jan. 15, 1986).[1] On January 21, 1986, the Comptroller General submitted his report to the President and the Congress appraising the accuracy of the CBO's and OMB's report and making minor changes. 51 Fed. Reg. 2813 (Jan. 21, 1986). Following the submission of the Comptroller General's report, on February 1, 1986, the President issued a "sequestration" order, containing the budget reductions mandated in the Comptroller General's report. This sequestration became effective on March 1, 1986. S. Doc. No. 24, 99th Cong., 2d Sess. (1986); *see* Act § 252(a)(6)(A), J.A. 129. Accordingly, as of March 1, funding for all non-exempt[2] health and education programs was cut by 4.3 percent and funding for the Medicare program was cut by one percent.

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[1] *See* Act § 256(d)(1)(A), J.A. 151 (setting the maximum permissible reduction for Medicare at one percent for fiscal year 1986).

The funds for health and education programs subject to the President's sequestration had all been duly authorized and appropriated by Congress.[3] The health and education programs funded under these appropriations acts include preschool, elementary, secondary and higher education, and a full range of health programs involving research, training, prevention and services. Specific programs include migrant education; early childhood education for handicapped children; student assistance for college and graduate students; maternal and child health grants; family planning services; exceptional need scholarships for health professions students; childhood immunization programs; clinical training for mental health researchers; and biomedical research on numerous life-threatening diseases, such as cancer and Acquired Immune Deficiency Syndrome (AIDS).

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[2] Certain programs are totally exempt from Gramm-Rudman cuts. Medicaid, for example, is totally exempt. Act § 255(h), J.A. 148. Other programs are subject to special rules. *Id.* § 256, J.A. 148-158. These programs include: the Guaranteed Student Loan program, which was subject to a mandatory reduction of .4 percent in the special allowance for lenders and a .5 percent increase in the loan origination fee (51 Fed. Reg. 1932); the Community Health Centers and Indian Health Services programs, which received a one percent reduction (51 Fed. Reg. 1934); and the Vocational Rehabilitation grant program, which was subject to a reduction in the expected automatic spending increase (51 Fed. Reg. 1927, 1933).

[3] Department of Labor, Health and Human Services, Education and Related Agencies Appropriations Act for the Fiscal Year Ending September 30, 1986, Pub. L. No. 99-178, 99 Stat. 1102 (1985); Further Continuing Appropriations Act of 1985, Pub. L. No. 99-190, 99 Stat. 1185 (1985). Payment under the Medicare program is authorized under Title XVIII of the Social Security Act of 1965, as amended, Pub. L. No. 89-97 (codified at 42 U.S.C. § 1395 *et seq.*).

B. The District Court's Decision

On February 7, 1986, the three-judge district court held that the Deficit Control Act violates the separation of powers doctrine by granting executive powers to the Comptroller General, an officer removable by Congress. Because of this constitutional defect, the court concluded that "those powers cannot be exercised and therefore the automatic deficit reduction process to which they are central cannot be implemented." J.A. 78. The court issued an order declaring the automatic reduction process unconstitutional and declaring the February 1, 1986 presidential sequestration order issued pursuant to those unconstitutional procedures "without legal force and effect." J.A. 81-82. The court, as required by the judicial review provisions of the Act, stayed the effect of its judgment pending these appeals. J.A. 82.

SUMMARY OF ARGUMENT

In holding that the automatic deficit reduction procedures of the Deficit Control Act violate the separation of powers doctrine, the district court not only held that the application of the Act to future budget reductions is unconstitutional; it also declared the first reductions under the Act null and void. *Amici* endorse the arguments of Appellees in support of the district court's analysis of the constitutional issues. This brief, however, will be limited to the single issue of the district court's ruling that, because the budget reductions were made pursuant to unconstitutional procedures, the February 1, 1986 sequestration order is void and without legal effect.

In so ruling, the district court properly applied the longstanding rule of Anglo-American jurisprudence that judicial decisions are to be accorded retroactive treatment.

Nothing in this Court's decisions, including the standards established in *Chevron Oil Co. v. Huson*, 404 U.S. 97 (1971), dictate a departure from the normal rule of retroactivity. First, the district court's decision did not overturn prior law upon which individuals had relied. There was no justifiable reliance on the validity of the Deficit Control Act, since its dubious constitutionality was foreshadowed well before it was enacted into law and it was subject to constitutional challenge from the moment it became effective. In the absence of appropriate reliance, retroactive relief should be applied.

Second, retroactive application of the district court's decision furthers the purpose of the court's decision by denying effect to the unconstitutional withholding of duly authorized funds. Third, the equities in this case clearly favor voiding the sequestration order and restoring the funds to the innocent third parties, such as *amici*, who have had their legal rights to funds extinguished by unconstitutional procedures. Accordingly, *amici* urge the Court to affirm the district court's order entirely, including its order that the budget reductions wrongfully taken are null and void, with the effect that these reductions in lawful appropriations must be restored to the affected programs.

ARGUMENT

I. BECAUSE THE PRESIDENT'S SEQUESTRATION ORDER WAS BASED ON AN UNCONSTITUTIONAL PROCEDURE, THE ORDER IS NULL AND VOID OF ANY LEGAL EFFECT, AND THE FUNDS PERMANENTLY CANCELLED UNDER SUCH ORDER MUST BE RESTORED

The district court properly held that, since the automatic deficit reduction procedures are unconstitutional, the February 1, 1986 sequestration order issued pursuant to those procedures is null and void of any legal effect. J.A. 81-82. Moreover, in the context of discussing ~~whether the~~ National Treasury Employees Union ("NTEU") had standing to challenge the constitutionality of the Act, the court indicated that a judicial decision declaring the Deficit Control Act unconstitutional would require the restoration of funds:

> As to at least the second of the injuries of which NTEU complains—the imminent permanent cancellation of its members' COLA benefits by the operation of the presidential sequestration order—it is unquestionable that a judicial remedy exists. *If we declare the automatic deficit reduction process invalid, no cancellation of the COLA benefits will occur as a result of that process.* Rather, the fallback deficit reduction process established by subsection 274(f) will come into play, and any cancellation of COLAs under that process will require the passage of legislation.

J.A. 35 (footnotes omitted and emphasis added).

Nothing in this Court's decisions indicate that the district court's holding should not be applied retroactively. In *Chevron Oil Co. v. Huson*, 404 U.S. 97 (1971), the Court established a three-part test for determining whether in a civil case a decision should be treated retroactively:

- *First*, the decision to be applied nonretroactively must establish a new principle of law, either by overruling clear past precedent on which litigants may have relied . . . or by deciding an issue of first impression whose resolution was not clearly foreshadowed. . . .
- *Second*, it has been stressed that "we must . . . weigh the merits and demerits in each case by looking to the prior history of the rule in question, its purpose and effect, and whether retrospective operation will further or retard its operation." . . .
- *Finally*, "[w]here a decision . . . could produce substantial inequitable results if applied retroactively, there is ample basis . . . for avoiding the 'injustice or hardship' by a holding of nonretroactivity."

Id. at 106-07 (citations omitted and emphasis added). The *Chevron* test developed as an exception to the longstanding rule of Anglo-American law that judicial decisions are retroactive[4] to account for those extraordinary circumstances where the Court deemed it appropriate to depart from the normal rule of retroactivity.

The initial *Chevron* factor—establishing a clear break from prior law upon which the parties relied—is the threshold test for determining whether a decision should be applied retroactively:

> Once it has been established that a decision has "establish[ed] a new principle of law, either by overruling clear past precedent on which litigants may have relied . . . or by deciding an issue of first impression whose resolution was not clearly foreshadowed," the Court has gone on to examine the history, purpose, and effect of the new rule, as well as the

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[4] *See, e.g.*, Linkletter v. Walker, 381 U.S. 618, 622-23 and n.6 (1965); Norton v. Shelby County, 118 U.S. 425, 442 (1886).

> inequity that would be imposed by its retroactive application.

United States v. Johnson, 457 U.S. 537, 550 n.12 (1982) (*quoting Chevron*, 404 U.S. at 106-107); *see also Cash v. Califano*, 621 F.2d 626, 631 (4th Cir. 1980) (reliance is the threshold factor). In virtually all of the civil cases in which decisions have been applied prospectively, courts have determined that retroactivity was inappropriate because individuals had relied on prior law and conformed their conduct to that prior law or the *status quo ante*.[5]

In contrast, this case does not involve a rule of law which regulates individual conduct and upon which individuals have relied. Rather, it involves whether certain federal budget procedures violate the separation of powers doctrine. Thus, by its very nature, retroactive application of the district court's decision in this case raises few, if any, of the difficult issues addressed by the *Chevron* factors and this Court's other retroactivity decisions. *See Chicot County Drainage District v. Baxter State Bank*, 308 U.S. 371, 374 (1940). Assuming the *Chevron* analysis nonetheless is the starting point for determining questions of retroactivity, the *Chevron* factors clearly support affirmance of the district court's decision to accord retroactive treatment to its order declaring the presidential sequestration order void of any legal effect.[6]

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[5] *E.g.*, Arizona Governing Committee for Tax Deferred Annuity and Deferred Compensation Plans v. Norris, 463 U.S. 1073, 1105-07, 1109-10 (1982) (plurality); Northern Pipeline Construction Co. v. Marathon Oil Co., 458 U.S. 50, 88 (1981); City of Los Angeles Dept. of Power and Water v. Manhart, 435 U.S. 702, 722-23 (1978); *Chevron*, 404 U.S. at 108.

[6] The courts have also recognized that application of the *Chevron* factors "is not accomplished through a discrete reference to each separate factor, but by an analysis of how they interact with one another." *Cash v. Califano*, 621 F.2d at 629. Thus, to deny retroactive application, a decision must not only meet the threshold

A. The Court's Decision Does Not Establish A New Principle Of Law

All of the cases in which this Court has applied decisions only prospectively emphasized the parties' appropriate reliance on the state of the law prior to the decision. Several of these cases announced completely new procedural interpretations which would have prejudiced potential plaintiffs relying on the former law from seeking relief. In *Chevron*, for instance, this Court applied prospectively its decision that the state statute of limitations applied in cases brought under the Outer Continental Shelf Lands Act, reasoning that when the plaintiff was injured and initiated his suit, he could not foresee that the prior interpretation of the statute would be overturned. "The most he could do was rely on the law as it then was." *Chevron*, 404 U.S. at 107.[7]

Other cases have involved substantive interpretations of laws in which parties had relied in good faith on prior legal precedent. In *Manhart*, this Court gave prospective treatment to its decision that Title VII of the Civil Rights Act of 1964 prohibits an employer from requiring women to make larger pension contributions in order to obtain the same monthly benefits as men, noting that its decision imposed "[d]rastic changes in the legal rules governing pension and insurance funds," and that the employer, relying on prior law, could have believed his pension plan was lawful. *Id.* at 720-21.[8]

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reliance factor; it must meet all of the *Chevron* factors. Cochran v. Birkel, 651 F.2d 1219, 1223 n.8 (6th Cir. 1981), *cert. denied*, 454 U.S. 1152 (1982).

[7] *See also Northern Pipeline*, 458 U.S. at 88; England v. Louisiana State Board of Medical Examiners, 375 U.S. 411, 422 (1964).

[8] *See also* Lemon v. Kurtzman, 411 U.S. 192 (1973) (plurality); City of Phoenix v. Kolodziejski, 399 U.S. 204, 213-15 (1970); Cipriano v. City of Houma, 395 U.S. 701, 706 (1969).

By contrast, in this case the dubious constitutionality of the Deficit Control Act was apparent even before the bill was signed into law. First, this Court's unanimous decision in *Buckley v. Valeo*, 424 U.S. 1 (1975) (per curiam), established unequivocally that legislative officials may not exercise executive duties.[9] In addition, this Court's decision in *INS v. Chadha*, 462 U.S. 919 (1983), established that legislation—as well as the repeal of duly authorized legislation—can only be enacted through constitutionally prescribed procedures. Certainly these decisions paved the way for the conclusion that the Deficit Control Act violated the fundamental principle of separation of powers.

Second, the legislative history of the Act demonstrates that Congress itself recognized that the automatic deficit reduction procedures raised serious constitutional concerns. During congressional debate on the Gramm-Rudman bill, members of Congress observed several constitutional defects in the Act.[10] Professor Laurence H.

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[9] Appellant Comptroller General points to a footnote in *Buckley v. Valeo* (424 U.S. at 128 n.165) to argue that that decision upheld the Comptroller General's authority to exercise administrative functions. Brief for Appellant Comptroller General of the United States ["GAO Brief"] at 29. Yet nothing in this Court's casual reference to the Comptroller General indicates that, as an officer removable by Congress, he is authorized to exercise the executive functions conferred on him under the Deficit Control Act. Indeed, the footnote does not even address the removal issue. Rather, the decision makes clear that "administrative functions may . . . be exercised only by persons who are 'officers of the United States.'" 424 U.S. at 141 (footnote omitted).

[10] Just prior to House passage, Representative Oakar read a letter into the record from the Chairman of the House Judiciary Committee, Representative Rodino, detailing his opposition to the bill on the grounds that this Court's decision in *Chadha* established that "Congress cannot undo a law by anything short of a new law, and that all laws must be adopted through . . . constitutionally mandated procedures . . ." and that this Court's decision in *Buckley v. Valeo* reaffirmed that "the principle of separation of powers was

Tribe also expressed his views to the Congress that the bill contained "serious [constitutional] infirmities that merit the closest attention" and that "[g]iving executive duties to a legislative officer is almost certainly unconstitutional," citing *Buckley v. Valeo.*[11]

Given these concerns regarding the constitutionality of the Act, the framers included provisions facilitating constitutional challenge. First, the Act includes a provision conferring standing upon Members of Congress to seek a declaratory judgment and injunctive relief concerning the constitutionality of the Act. Act § 274(a)(2), J.A. 163. Second, the Act includes provisions for expedited judicial review of a constittuional challenge. *Id.* § 274 (c), J.A. 164.

Moreover, Congress included in the Act a so-called "fallback deficit reduction" provision to be employed in the event the automatic deficit reduction process were declared unconstitutional. Act § 274(f), J.A. 165-66. Under the fallback provision, budget reductions can be required only by a joint resolution of Congress, signed by the President. *Id.* The fallback provision thus represents an implicit admission by Congress that if the Act were declared unconstitutional, the budget reductions would be invalid and would have to be restored, absent lawfully enacted legislation. Indeed, Appellant Comptroller General of the United States concedes this point in his brief by observing that, "[s]ince this fallback depends on the passage of another law, it is essentially a return to the *status quo ante.*" GAO Brief at 5.

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not simply an abstract generalization . . . ." 131 Cong. Rec. H11893-94 (daily ed. Dec. 11, 1985); *see also id.* H11881 (Rep. Waxman) (court should rule the law unconstitutional); *id.* H11885 (Rep. Rodino) (bill is unconstitutional); *id.* H11891 (Rep. Levine) (same).

[11] 131 Cong. Rec. H9608-09 (Nov. 1, 1985) (letter from Professor Laurence H. Tribe to Hon. Mike Synar (Oct. 22, 1985)).

Even the President, when signing the Gramm-Rudman bill into law, observed that the bill raised "serious constitutional questions":

> In signing [the Gramm-Rudman] bill, I am mindful of the serious constitutional questions raised by some of its provisions. The bill assigns a significant role to the Director of the Congressional Budget Office and the Comptroller General in calculating the budget estimates that trigger the operative provisions of the bill. Under the system of separated powers established by the Constitution, however, executive functions may only be performed by officers in the Executive Branch. The Director of the Congressional Budget Office and the Comptroller General are agents of Congress, not officers in the Executive Branch.[12]

Finally, Representative Synar initiated his suit seeking declaratory relief on the constitutionality of the Act on December 12, 1985, the same day the bill was signed into law. Thus, there was a constitutional cloud over the Act from the moment it became effective. No one could have placed any reliance on the validity of the Act at any point, for all the actions taken pursuant to its provisions took place well after its constitutionality was challenged.

A decision declaring the Deficit Control Act unconstitutional thus does not overrule clear precedent; indeed, such an outcome was foreshadowed by *Buckley v. Valeo*, as well as other Supreme Court precedent. Second, the decision does not change existing law upon which the parties relied. In *National Ass'n of Broadcasters v. FCC*, 554 F.2d 1118 (D.C. Cir. 1976), the United States Court of Appeals for the District of Columbia Circuit applied a decision of this Court retroactively to require the FCC to refund illegally assessed fees where the FCC was unable to demonstrate justifiable reliance on the old rule:

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[12] President's Statement on Signing H.J. Resolution 327 Into Law, 21 Weekly Comp. Pres. Doc. 1490, 1491 (Dec. 12, 1985).

> since the FCC had notice almost from the time it adopted the schedule that it would be subject to a challenge in court, there could be no justifiable reliance here. . . . For the same reason, because of the immediate protests and refund requests made by the petitioners, we reject any idea that the Commission would be unfairly surprised by our action today as well as the notion that petitioners' "transactions" had become final and should not be disturbed.

Id. at 1132 (footnotes omitted). The same is true in this case. From the day the bill was signed into law it was subject to a constitutional challenge, thereby removing any possibility that Appellants could be unfairly surprised by the district court's decision.

This Court has recognized that in the absence of justifiable reliance on the prior law, there is no basis for limiting relief prospectively. *See Johnson*, 457 U.S. at 550 n.12; *Lemon v. Kurtzman*, 411 U.S. at 203-06. In light of the extraordinary amount of concern over the constitutionality of the Act, and the fact that it was challenged in court on the day it became effective, there simply was no basis for reliance on the validity of the Act. Thus, since this case does not even meet the threshold reliance factor, there is no reason to apply the decision prospectively. Accordingly, the retroactivity analysis need go no further.[13]

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[13] *See Johnson*, 457 U.S. at 550 n.12; Valencia v. Anderson Bros. Ford, 617 F.2d 1278, 1289 (7th Cir. 1980) ("Having decided that our ruling in this case establishes no new principle of law, it is unnecessary to address the remaining prongs of the *Chevron Oil* test"), *rev'd on other grounds*, 452 U.S. 205 (1981); Schaefer v. First National Bank, 509 F.2d 1287, 1294-95 (7th Cir. 1975), *cert. denied*, 425 U.S. 943 (1976); Cash v. Califano, 621 F.2d at 631.

B. Requiring Restoration Of The Unlawfully Cancelled Funds Would Further The Purposes Of The Court's Decision

Even assuming, *arguendo*, that the remaining factors of the *Chevron* test need be considered, it is clear that retroactive application of the district court's decision was appropriate. The second factor under the *Chevron* framework is whether, considering the purposes and effect of the court's ruling, retroactive application "will further or retard its application." *Chevron*, 404 U.S. at 107. Thus, in *Chevron*, this Court determined that a primary purpose of the Lands Act in adopting the state statute of limitations as federal law was to aid injured employees by affording them complete and familiar remedies. Thus, to apply its decision retroactively to bar the plaintiff's claim would be "inimical to the beneficent purpose of the Congress." *Id.* at 108.

In this case, the purpose of an affirmance of the district court's order invalidating the automatic deficit reduction procedures is to maintain the delicate balance and separation of powers which underlie our constitutional framework of government. A prospective-only decision in this case which did not require restoration of withheld funds would retard operation of the rule by sanctioning the reduction of funds pursuant to unconstitutional means. It is well established that the Executive lacks any inherent constitutional power to refuse to spend funds duly appropriated by Congress. *Kendall v. United States ex. rel. Stokes*, 37 U.S. 524 (1838); *State Highway Comm'n v. Volpe*, 479 F.2d 1099 (8th Cir. 1973); *National Council of Community Health Centers, Inc. v. Weinberger*, 361 F. Supp. 897 (D.D.C. 1973). Actions taken pursuant to unconstitutional procedures have no legal effect. *See INS v. Chadha*, 462 U.S. 919 (1983). Moreover, this Court has recognized in constitutional adjudication and elsewhere that federal courts have broad equitable powers to shape relief to meet the necessities of a particular case. *E.g.*, *Lemon v. Kurtzman*, 411 U.S. at 200-01; *Brown v. Board of Education*, 349 U.S. 294, 300 (1955).[14] Thus, affirmance of the district court's order would further implementation of the constitutional rule.

C. The Equities In This Case Clearly Favor Restoring The Unlawfully Cancelled Funds

The final factor considered under the *Chevron* standard is whether retroactive application of the decision would produce "substantial inequities." *Chevron*, 404 U.S. at 107. This inequity factor is closely tied to the initial reliance factor. In *Cipriano v. City of Houma*, for example, this Court concluded that retroactive application of its decision would impose "[s]ignificant hardships . . . on cities, bondholders, and others connected with municipal utilities" who had relied in good faith on the validity of the municipal financing scheme. 395 U.S. at 706. Similarly, in the *Chevron* decision itself, this Court concluded that retroactive application of its decision on the applicable statute of limitations "would also produce the most 'substantial inequitable results' to hold that the respondent 'slept on his rights' at a time when he could not have known the time limitation that the law imposed upon him." *Chevron*, 404 U.S. at 108 (citations omitted).

This Court has also applied the doctrine of nonretroactivity where the parties that would have been adversely affected by the Court's decision were innocent of any wrongful conduct. In *Norris*, this Court denied retroactivity where, under the new rule, "[t]he harm would fall in large part on innocent third parties." 463 U.S. at 1110 (O'Conner, J., concurring) (*quoting Manhart*, 435 U.S. at 722-23); *see also Cipriano*, 395 U.S. at 706.

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[14] For example, the federal district courts have equitable power to require funds improperly withheld to be made available for their designated purposes even where funds have reverted to the treasury, *e.g.*, International Union, United Automobile, Aerospace and Agricultural Implement Workers of America v. Donovan, 570 F. Supp. 210, 220 (D.D.C. 1983), or to require that funds improperly withheld in one fiscal year be spent in the following fiscal year, along with funds specially appropriated for that second fiscal year. Kennedy v. Mathews, 413 F. Supp. 1240, 1245 (D.D.C. 1976).

In this case, retroactive application of the district court's decision would not produce such inequitable results. Indeed, *non*retroactive application of the decision would cause just the type of harm to innocent third parties, such as *amici* and their members, that this Court felt obligated to avoid in *Norris* and *Manhart*. The automatic deficit reductions have resulted in substantial harm to third parties who have been wrongfully denied their legal rights to federal funds. Indeed, because the sequestration order imposes across-the-board percentage reductions, smaller programs are most acutely affected by the unlawful withholding of funds. A chart illustrating the sequestered amounts in selected health and education programs is set forth in the Appendix attached hereto. These include mandated budget cuts eliminating:

- $236 million in funding for the National Institutes of Health ("NIH") research support, necessitating across-the-board funding cuts in all on-going research and training programs, irrespective of need or merit;[15]
- one percent in payments to all hospitals, physicians, nurses, clinics, nursing homes, medical equipment suppliers and other health care providers participating in the Medicare program who are already operating at severely reduced levels of reimbursement;[16]

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[15] U.S. Department of Health and Human Services, Report on Sequestration Under the Balanced Budget and Emergency Deficit Control Act of 1985 (Gramm-Rudman-Hollings) for Committee on Appropriations 1986, 63-92 (1986) ["HHS Sequestration Report"].

[16] U.S. Department of Health and Human Services, Health Care Financing Administration, Transmittal No. 86-2 (Feb. 1986) (in-

- $10,077,000 in funding for AIDS research at a time when scientists are coming closer to identifying the cause of and the cure for this fatal disease;[17]
- 424 training grants awarded to young researchers by the NIH;[18]
- funding for 65,000 children to receive immunizations against childhood diseases;[19]
- thirty-five grants of regional and national significance from the Maternal and Child Health program;[20]
- funds under the Community Health Centers program to expand health services in ten rural communities for an additional 50,000 people;[21]
- eighteen health professions scholarships for students in exceptional financial need;[22]
- traineeship positions for 252 public health and 100 nursing students;[23]

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structions to Medicare intermediaries for implementing one percent reduction in payments); Department of Health and Human Services, Health Care Financing Administration, Transmittal No. LM86-1 (Feb. 1986) (instructions to Medicare carriers for implementing one percent reduction in payments).

[17] S. Doc. No. 24, 99th Cong., 2d Sess. 397-430 (1986).

[18] HHS Sequestration Report at 65.

[19] Hearings on the Federal Childhood Immunization Program before the Subcommittee on Health and the Environment of the House Committee on Energy and Commerce (Mar. 10, 1986) (statement of Chairman Waxman).

[20] HHS Sequestration Report at 5.

[21] *Id.* at 6.

[22] *Id.* at 16.

[23] *Id.* at 18, 24.

- some 290,000 middle-income college students from the Pell grant financial assistance program;[24] and
- twenty-eight projects and service to 9,209 students under the bilingual education program.[25]

Clearly the equities in this case favor the intended recipients of federal funds, such as amici, who have had their legal rights to duly authorized funds extinguished pursuant to an unlawful procedure. "[T]he equities weigh more heavily in favor of granting retroactive relief where the party bearing the burden of retroactive application can be charged with acting unlawfully." *Atlantic Richfield Co. v. FEA*, 463 F. Supp. 1079, 1086 (N.D. Cal. 1979). Simply because the restoration of funds will have a financial impact is insufficient to tip the scales of equity. "A financial impact alone is an insufficient basis to mandate nonretroactivity." *Cash v. Califano*, 621 F.2d at 632.

Moreover, as noted, since the constitutionality of the Act has always been in question, there was no basis for any reliance on its validity. In the absence of some surprise engendered by a new decision, the Appellants can hardly claim that equities support a ruling of nonretroactivity. Accordingly, this Court should affirm the district court's decision, thus requiring restoration of all funds unlawfully cancelled.

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[24] The Committee for Education Funding, Budget Impact Alert, The President's Proposed Budget for Education and Its Impact for Fiscal Year 1986, 82 (1986).

[25] *See generally id.* at 61.

CONCLUSION

For the reasons set forth herein, the decision of the district court should be affirmed.

Respectfully submitted,

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April 9, 1986

APPENDIX

List of *Amici Curiae*

American Council on Education

American Hospital Association

Coalition for Health Funding on behalf of:

- American Academy of Pediatrics
- American Association of Colleges of Nursing
- American Association of Colleges of Pharmacy
- American Association of Colleges of Podiatric Medicine
- American Association for Dental Research
- American Association of Dental Schools
- American Heart Association
- American Lung Association
- American Nurses Association
- American Public Health Association
- Association of American Veterinary Medical Colleges
- Association of Schools of Public Health
- Association of University Programs in Health Administration
- Cystic Fibrosis Foundation
- Infectious Diseases Society of America
- March of Dimes Birth Defects Foundation
- National Association of Children's Hospitals and Related Institutions
- National Family Planning and Reproductive Health Association
- National Leaque for Nursing
- Planned Parenthood Federation of America

Juvenile Diabetes Foundation International

National School Boards Association

Western Association of Children's Hospitals

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Effects of the March 1, 1986 Sequestration Order on Selected Appropriated Health and Education Programs *

DEPARTMENT OF EDUCATION

(selected programs)

Program, project, activity	Amount Sequestered
Compensatory education for the disadvantaged	
Grants to local education agencies	$137,600,000
State agency migrant programs	11,375,000
Handicaped	6,457,000
Neglected and delinquent	1,402,000
Education for the Handicapped	
State grant program	52,268,000
Preschool incentive grants	1,290,000
Deaf-blind centers	645,000
Severely handicaped projects	215,000
Early childhood education comprehensive service delivery systems	310,000
Four deaf institutions	86,000
Vocational Rehabilitation	
State allotments	44,852,000
Client assistance	288,000
Innovation and expansion	387,000
Independent living comprehensive service	473,000
Independent living centers	989,000
Services for the older blind	215,000
Training of interpreters for the deaf	39,000
Prosthetic and orthotic education	65,000
Evaluation	77,000
National Institute of Handicapped Research	1,892,000
Helen Keller Center	185,000

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* S. Doc. No. 24, 99th Cong., 2d Sess. (1986).

	Amount Sequestered
Basic grants (Title II)	$ 33,132,000
Community-based organizations (Title III-A)	322,000
National center for research in vocational education	258,000
Student Financial Assistance	
Pell grants	154,284,000
Supplemental educational opportunity	17,738,000
Work-study	25,477,000
Higher Education	
Minority institutions science improvement	215,000
Special programs for the disadvantaged	7,584,000
Special higher education projects (Center for Excellence)	258,000
Graduate/professional opportunity fellowships	505,000
Public service fellowships	107,000
National graduate fellowships	107,000
Legal training for the disadvantaged	65,000
Law school clinical experience	65,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
(selected programs)

Food and Drug Administration	
Orphan drug product grants and contracts	129,000
Acquired Immune Deficiency Syndrome (AIDS)	428,000
Health Resources and Services	
Maternal and child health state block grant	17,471,000
Black lung clinics	146,000
Family planning	6,128,000
Exceptional needs scholarships	301,000

	Amount Sequestered
Health administration grants	$ 64,00
Public health traineeships	129,000
Preventive medicine residencies	69,000
Family medicine departments	301,000
Family medicine and general dentistry residencies and training	1,548,000
Area health education centers	774,000
Disadvantaged assistance	1,097,000
Advance nurse training	710,000
Nurse traineeships	495,000
Nurse fellowships	86,000
Organ transplant network	17,000
Centers for Disease Control	
Prevention centers	64,000
Sexually transmitted diseases grants	2,000,000
Immunization grants	2,036,000
Immunization direct operations	354,000
Vaccine stockpile	172,000
New drugs for AIDS	297,000
Infectious diseases	2,027,000
National Institutes of Health	
Research project grants:	
New and competing grants	41,052,000
Renewal grants	88,978,000
Supplemental grants	753,000
Other research:	
Research centers	20,977,000
Other research	13,383,000
Research and development contracts	16,044,000
Research management and support	9,247,000
Intramural research	25,125,000
Research training awards	9,409,000
Disease control and construction	3,117,000
National Library of Medicine	2,486,000
Office of the director	5,031,000
Buildings and facilities	641,000

	Amount Sequestered
Alcohol, Drug Abuse and Mental Health Administration	
Mental health research AIDS research	$ 166,000
Mental health research All other	9,036,000
Training of health professionals in the identification & treatment of alcohol & drug abuse	43,000
Mental health clinical training all other	817,000
Drug abuse research AIDS research	239,000
Drug abuse research training	65,000
Alcoholism research training	64,000
Health Service Management	
Health services research	637,000
Smoking and health	151,000
Survey improvements for long-term care facilities & intermediate care facilities for the mentally retarded	22,000

Mr. LAWTON. We argued that the lower court's decision that the February 1 sequestration order was null and void should be upheld and all sequestered funds restored under the long-standing rule that judicial decisions usually are to be accorded retroactive treatment.

If this argument was unconstitutional back in February, it is unconstitutional now. We want our money back.

If these arguments are accepted by the Supreme Court, the sequestered funds will be restored and the Congress will be empowered to spend these funds, absent a legislative enactment rescinding them.

It is the hope of the Coalition that the funds currently withheld from expenditure will be returned to the PHS programs from which they were taken in order to ameliorate the backsliding occasioned by the precipitous Gramm-Rudman cuts.

Abolition by the Supreme Court of the sequestration process scheduled to go into effect once again in September will certainly return this committee to its pivotal position in determining health funding policy, and will assure that the next round of across-the-board cuts, estimated conservatively by the Congressional Budget Office at 8.4 percent, will never go into effect.

Even absent a favorable ruling by Supreme Court, however, the Gramm-Rudman juggernaut must be stopped as it represents a deadly serious menace to public health. The Coalition has always looked to your committee to provide the leadership necessary to protect and sustain the PHS programs.

We again ask for your help to assure that PHS research, training and service programs are spared from the ravages of Gramm-Rudman, and in fiscal year 1987 receive funding increases necessary to offset the insidious effects of inflation and provide for real growth and progress toward a healthier America.

Mr. Chairman, I thank you and Congressman Conte and your staff for your continued support for public health programs. We deeply appreciate your leadership and will be happy to answer any questions that you may have.

[The statement of Mr. Lawton follows:]

COALITION
FOR
HEALTH FUNDING

Statement

of

Stephan E. Lawton, Esq., Counsel

Coalition for Health Funding

on

FY 1987 Appropriations

for the

U.S. Public Health Service

before

House Labor, Health and Human

Services and Education Appropriations

Subcommittee

April 29, 1986
Washington, D.C.

1200 EIGHTEENTH STREET, N.W., SUITE 1000 WASHINGTON, D.C. 20036 (202) 833-2358

Mr. Chairman, and members of the committee, my name is Stephan E. Lawton. I am a partner at the Washington, D.C. law firm of Pierson, Ball & Dowd and serve as general counsel to the Coalition for Health Funding (Coalition). Prior to entering private practice, I served as Chief Counsel to the Subcommittee on Health and the Environment of the United States House of Representatives from 1971 to 1978. As you know, that subcommittee developed most substantive health legislation enacted by the Congress during the 1970s, including laws affecting health professions education and biomedical research programs, health planning, health maintenance organizations, environmental laws and food and drug laws.

The Coalition for Health Funding, which I am representing today, is composed of over 40 national health organizations that represent voluntary health agencies, consumers and providers of health services, the institutions that train health professionals and others. The thread that unites these diverse groups is an overriding concern for the Public Health Service's (PHS) research, service and training programs.

The Coalition is deeply concerned about the impact the Balanced Budget and Emergency Deficit Control Act -- more commonly known as Gramm-Rudman -- has had and will have on discretionary health programs. As you well know, Gramm-Rudman has initiated a process euphemistically called sequestration.

Briefly put, sequestration is a process whereby the deficit for the upcoming year is determined, and, if it exceeds a predetermined "maximum deficit amount," necessary budget reductions are calculated. Ultimately, any deficit excess is cured by a sequestration order issued by the president.

On February 1, 1986, the president issued just such an order which became effective on March 1, 1986. The order mandated 4.3 percent cuts in funding for virtually all of the discretionary health programs, with the exception of the Community and Migrant Health Centers programs which sustained a one percent cut. Perhaps a 4.3 percent funding reduction does not sound like very much, but as a direct result of that sequestration:

- $236 million in funding for the National Institutes of Health ("NIH") research support was eliminated, necessitating across-the-board funding cuts in all on-going research and training programs, irrespective of need or merit;
- Over $10 million in funding for AIDS research was cut at a time when scientists are coming closer to identifying a vaccine that can prevent this fatal disease;
- 424 training grants that were to be awarded to young researchers by the NIH were eliminated;

- Funding sufficient to allow 65,000 children to receive immunizations against childhood diseases was deleted;
- Thirty-five grants of regional and national significance were cut from the Maternal and Child Health program;
- Funds to allow the Community Health Centers program to expand health services in ten rural communities for an additional 50,000 people were lost;
- Eighteen health professions scholarships for students in exceptional financial need were never awarded; and
- Planned traineeship positions for 252 public health and 100 nursing students were abandoned.

Mr. Chairman, these cuts I've just described, and many like them that time will not permit me to detail, had a profound impact on our nation's biomedical research effort, the health of our children and various health professions training programs designed to assure the continued availability of the most highly qualified nurses, physicians, dentists, public health workers and the like.

Perhaps the most disturbing aspect of the Gramm-Rudman inspired cuts was their indiscriminate nature. Each program funded under the auspices of the PHS is unique -- be it family planning or immunizations grants. And it used to be exclusively within the purview of **this committee** to gauge the essential financial requirements of each PHS program and to fund them accordingly, based on extensive and exacting hearings. Gramm-Rudman, however, effectively reduces the studied recommendations of this committee to rhetoric because of its power to virtually obliterate Committee judgments by means of a mindless, unfeeling, unthinking, bloodless formula: a result which has the very real potential to undo much of progress in health care and research assiduously fostered by this committee.

As you may know, the Coalition submitted an amicus curiae brief in the Gramm-Rudman case, which was argued before the U.S. Supreme Court on April 23, 1986. In its brief, the Coalition asked that the Supreme Court affirm the decision of the lower court that the automatic sequestration process is unconstitutional as a violation of the principles of separation of powers. Further, the Coalition argued that the lower court's decision that the February 1 sequestration order was null and void should be upheld and all sequestered funds restored under the long standing rule that judicial decisions usually are to be accorded retroactive treatment. If these arguments are accepted by the Supreme Court, the sequestered funds will be restored and the congress will be empowered to spend these funds, absent a legislative enactment rescinding them. It is the hope of the Coalition that the funds currently withheld from expenditure will be returned to the PHS programs from which they were taken in order to ameliorate the backsliding occasioned by the precipitious Gramm-Rudman cuts.

Abolition by the Supreme Court of the sequestration process scheduled to go into effect once again in September will certainly return this committee to its pivotal position in determining health funding policy, and will assure that the next round of across-the-board cuts -- estimated conservatively by the Congressional Budget Office (CBO) at 8.4 percent -- will never go into effect. Even absent a favorable ruling by the Supreme Court, however, the Gramm-Rudman juggernaut must be stopped as it represents a deadly serious menace to public health. The Coalition has always looked to your committee to provide the leadership necessary to protect and sustain the PHS programs. We again ask for your help to assure that PHS research, training and service program are spared from the ravages of Gramm-Rudman and in fiscal year 1987 receive funding increases necessary to offset the insideous effects of inflation and provide for real growth and progress toward a healthier America.

Mr. Chairman, I thank you again for your support for public health programs. We sincerely appreciate your leadership. I will be happy to answer any questions you or the other members of the committee may have.

COALITION FOR HEALTH FUNDING

COALITION FOR HEALTH FUNDING MEMBERSHIP

American Academy of Pediatrics
American Association for Dental Research
American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of Colleges of Podiatric Medicine
American Association of Dental Schools
American Association of University Affiliated Programs for the Developmentally Disabled
American Dental Association
American Heart Association
American Lung Association
American Nurses' Association
American Optometric Association
American Psychiatric Association
American Public Health Association
Association of American Universities
Association of American Veterinary Medical Colleges
Association of Physician Assistant Programs
Association of Schools of Public Health
Association of State and Territorial Health Officials
Association of University Programs in Health Administration
Citizens for the Treatment of High Blood Pressure
Cystic Fibrosis Foundation
Infectious Diseases Society of America
March of Dimes Birth Defects Foundation
National Association for Biomedical Research
National Association for Music Therapy
National Association of Childrens Hospitals and Related Institutions
National Association of Community Health Centers
National Association of State Universities and Land Grant Colleges
National Council Against Mental Illness
National Family Planning and Reproductive Health Association
National Health Education Committee
National Initiative for Glaucoma Control
National League of Nursing
National Student Nurses' Association
New York State Committee for the Treatment of High Blood Pressure
Planned Parenthood Federation of America
Society for Investigative Dermatology

1200 EIGHTEENTH STREET, N.W., SUITE 1000 WASHINGTON, D.C. 20036 (202) 833-2358

Mr. NATCHER. Thank you. You have made an excellent statement. We appreciate your appearance before the committee.

Mr. CONTE. You are aware that I am one of the original plaintiffs in that suit?

Mr. LAWTON. We are aware, and we appreciate that, and I think, quite frankly, you have got a lot of guts for doing that. Sometimes this stuff plays well back home, sometimes it doesn't.

We also appreciate your being so gracious to Dr. Wolf throughout the years.

Mr. NATCHER. Thank you very much.

TUESDAY, APRIL 29, 1986.

NATIVE AMERICAN PROGRAMS

WITNESS

HON. BILL RICHARDSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mr. NATCHER. Our next witness is our friend and colleague, Bill Richardson.

Mr. RICHARDSON. Thank you, Mr. Natcher.

I want to thank you and your staff for all the help you have given us throughout the years. I am here to make a simple appeal and ask unanimous consent that my statement be inserted in the record.

My appeal is for Navajo Community College, a community college in Shiprock, New Mexico. This is a Navajo area, and I am asking the committee to consider, if appropriate, funding $2,000,000 for renovation and curriculum changes, for a college campus that no longer can be called a campus, because of its deteriorating condition.

We have all heard of the effects of Gramm-Rudman on many programs, but I physically saw the deterioration of this campus. I saw the students without any morale. This is the main higher educational institution in my area and bureaucratically, I must tell you that neither the BIA, nor the Navajo tribe has it high on their priority list.

I don't know why they are ignoring it, but I am hopeful that this committee will seriously consider in some way appropriating these funds for this desparate situation involving the Navajo people.

The Navajo Community College literally is about to fall down, and I had not prepared this request until I physically saw the campus itself. I respectfully hope that this committee can find a way to help me specifically with this institution, this community college, which provides a very valuable service, but is now literally falling apart.

With all due respect, Mr. Chairman, I rest my case, and hope that you consider this request.

Mr. NATCHER. Mr. Richardson, it is a pleasure having you before the committee. You have made an excellent statement. We appreciate your appearance before the committee.

Mr. Conte.

Mr. CONTE. Bill is a good friend of mine, and I want to make this observation, that he makes a much better presentation here than he does on the pitching mound.

Mr. NATCHER. I see what you mean.

Mr. RICHARDSON. I am trying to get my fast ball back.

Mr. NATCHER. You come back to see us. Thank you very much.

TUESDAY, APRIL 29, 1986.

NATIONAL PELL GRANT COALITION

WITNESS

CHARLES R. WETHINGTON, JR., VICE CHANCELLOR FOR COMMUNITY COLLEGES, UNIVERSITY OF KENTUCKY SYSTEM

Mr. NATCHER. Our next witness is Dr. Charles Wethington. We are pleased to have you before the committee at this time.

Mr. WETHINGTON. I am Charles Wethington, Chancellor for Community Colleges of the University of Kentucky system and Chairman of the National Council of State Directors of Community and Junior Colleges. I am testifying this morning on behalf of the National Pell Grant Coalition.

The Pell Grant Coalition consists of 25 organizations, including major higher education associations; professional groups such as the National Education Association, the American Federation of Teachers and the American Association of University Professors; civil rights organizations such as the NAACP; and several national student associations.

We have all joined the Coalition because, even as all Federal student aid programs are important, we recognize that the Pell Grant program is special and deserves priority attention from the Congress.

As you know, Mr. Chairman, the Pell Grant program is targeted to the very neediest students, those who would not be able to consider any kind of education past high school without Federal help.

About two-thirds of the recipients come from families with incomes below $12,000; about three-quarters come from families with incomes below $15,000.

Mr. Chairman, in the program's 13-year history, over 30,000,000 Pell Grants have given millions of students the chance they needed to obtain a college education and begin making their rightful contribution to society, becoming productive and successful in every field of endeavor from national defense to the arts, from agriculture to finance.

In the community colleges in Kentucky over the same period, more than 55,000 students have received Pell Grants.

To continue playing this role in building the Nation's future, Pell Grant benefits have to be high enough to provide genuine access to college for needy students. Since the 1970s, however, the purchasing power of the Pell Grant has slipped decidedly.

For example, the maximum grant covered nearly half of average college costs in 1979, but covers less than one-third of those costs today. Thanks to the leadership of you and your colleagues on the subcommittee, Mr. Chairman, this trend was arrested two years ago when you increased the maximum Pell Grant benefit, but we now face serious new threats of retrenchment in the program.

The first retrenchment could take place as early as this fall. Because of the initial Gramm-Rudman cutback and a serious miscalculation by the Education Department, there is a $370,000,000 gap between the funds needed for Pell Grants next term and the money currently appropriated.

If awards are reduced in the legally mandated way to accommodate this shortfall, about 500,000 students will lose part of their grants and another 300,000 students will lose all their aid.

In Kentucky's community colleges, an estimated 1,278 students will lose part of their grants, and another 1,071 students will lose all of their grants. At Elizabethtown Community College, for example, 217 students will be affected, about 10 percent of the entire student body of that small community college.

If, as an alternative to the reduction formula in the law, everyone's grants were cut across-the-board by a certain amount, such as $100, the loss in aid to individuals would still be unacceptably deep and would fall unfairly on the neediest students.

What is needed, Mr. Chairman, is a $270,000,000 supplemental appropriation, perhaps coupled with borrowing authority, to close the gap, prevent massive cutbacks to students, and thus keep faith with the grant level Congress promised last December.

It is also important that action be taken soon, before news of prospective cutbacks begins to affect student decisions about dropping out or not starting a college education next year.

Looking ahead to the following academic year, an even more severe retrenchment would be in the offing under the Administration's budget proposal for fiscal year 1987, which would take a million students off the Pell Grant rolls.

Mr. Chairman, we urge you and your colleagues to reject this approach and instead increase the maximum entitlement in fiscal year 1987 by $100. This carries a modest price tag, but would at least go part of the way toward meeting the increases in college costs expected by the time the appropriation takes effect.

Mr. Chairman, you and your colleagues can take justifiable pride in having given priority attention to Pell Grants in these years of budgetary stringency. Today we are simply asking that the program not be allowed to slide backwards again, because it is the most important embodiment of our national commitment to equal opportunity in higher education.

Thank you for your consideration. I think you well know that we in Kentucky and the community colleges, and the community colleges across the country are extremely pleased, appreciative and supportive of your efforts in behalf of the Pell Grant program.

We deeply appreciate that, and we ask your consideration in keeping this aspect of higher education financial aid available for needy students.

[The information follows:]

National
Pell
Grant
Coalition

1225 Connecticut Avenue NW, Suite 306, Washington, DC 20036 (202)833-5682

SPONSORING ORGANIZATIONS

American Association of Community and Junior Colleges
American Association of State Colleges and Universities
American Association of University Professors
American Association of University Women
American Federation of Teachers
ASPIRA
Association of Community College Trustees
California Community Colleges
California State University
City University of New York
El Congreso Nacionale de Asuntos Collegiales
Hispanic Higher Education Coalition
League of United Latin American Citizens
Mexican American Legal Defense and Education Fund
National Association for the Advancement of Colored People
National Association for Equal Opportunity in Higher Education
National Association of State Universities and Land-Grant Colleges
National Council of Educational Opportunity Associations
National Education Association
National Organization of Black University and College Students
National Student Roundtable
Office for the Advancement of Public Black Colleges
State University of New York
United Negro College Fund
United States Student Association

Mr. NATCHER. Thank you very much, Dr. Wethington. You have made an excellent statement. We appreciate your appearance before the committee.

TUESDAY, APRIL 29, 1986.

MEDICAL OFFICERS FOR MICRONESIA AND AMERICAN SAMOA

WITNESS

TERENCE ROGERS, DEAN, UNIVERSITY OF HAWAII AT MANOA

Mr. NATCHER. Our next witness is Mr. Terence Rogers. We are glad to have you before the committee at this time. Go right ahead now.

Mr. ROGERS. Mr. Chairman, and Mr. Conte, you will recall that the American presence in the Islands of Micronesia is a matter of deliberate national security policy, both for the availability of military basis and the denial of the same to other powers.

The health problems of Micronesia, and American Samoa, resemble more those of the so-called Third World rather than those associated with America jurisdictions. The people are beset with an array of tropical diseases and others related to poor hygiene that had been virtually eliminated in the U.S. and Western Europe by the turn of this century.

The support of our government has not been altogether parsimonious, but has taken the form of hospital construction, often of an inappropriately technological standard, the rotational presence of young National Health Service Corps doctors, and, among others, the program on which I report today, with the request of its continuation.

As the Micronesian governments approach their varying degrees of qualified independence, we regard it as important that their health care delivery manpower should be Micronesian, and in a different context, Samoan.

Through this subcommittee's recommendations, an appropriation was made to initiate the training of a new cadre of indigenous medical officers at a high level of training to replace those whose ranks are being rapidly thinned by retirement.

Although the appropriation was made for fiscal year 1985 and 1986, we did not actually receive an award until January 1986. The Office of Management and Budget delayed making the necessary apportionment to the Department of Health and Human Services, who had already approved our technical proposal.

Nevertheless, I am able to report substantial progress towards beginning instruction in September 1986. The curriculum design is at an advanced stage, based on a philosophical consensus reached by our faculty leadership and the health leadership from Micronesia and American Samoa.

The expression of Congressional interest culminating in an award of about $2,500,000 for the first three years had an electrifying effect on the participating Federated States of Micronesia, and with gratifying enthusiasm they rapidly concluded essential lease agreements, affiliations, liability indemnifications, arrangements for faculty and student housing, even down to minor details.

The HHS award provides for the renovation of certain structures, and the engineering plans for this are being completed as I sit here.

It is our pleasure to report the collegiality, critical, supportive and innovative that we have enjoyed from the DHHS.

Most of all, we wish to thank the subcommittee and your parent committee for the interest and support for the people of the Pacific Islands. We will need an appropriation of $6,500,000 in fiscal year 1987 and 1988 for a six-year award in 1988-1989, in order to complete a nine-year program, which will then terminate.

Thank you, Mr. Chairman.

Mr. **Natcher**. Thank you, Mr. Rogers. You have made an excellent statement. We appreciate your appearance before the committee. Thank you, sir.

[The statement of Mr. Rogers follows:]

TESTIMONY TO:

SUBCOMMITTEE ON LABOR, HEALTH AND
HUMAN SERVICES AND EDUCATION APPROPRIATIONS

CONGRESS OF THE UNITED STATES

BY

Dean Terence A. Rogers

MEDICAL OFFICER TRAINING PROGRAM FOR MICRONESIA AND AMERICAN SAMOA

April 28, 1986
2:25 p.m.

Description of Training Program

Introduction

It should be emphasized at the outset that the health conditions in Micronesia do not resemble at all those expected in U.S. jurisdictions. Sanitation, infectious disease problems and the whole level of health resemble those of the tropical third world, except for the absence of gross caloric deficit. Distances between population centers are huge and many families on remote atolls can reach those population centers only after days of travel in small boats across the open Pacific. The indigenous cultures are strong and dignified, but they have been eroded by "modernization", and the unemployed young people display their own version of the anomie which threatens the stability of other poor countries with stagnant economies world-wide.

At first sight, the Islands appear to typify all the western fantasies of serene verdure and white beaches, set by tranquil lagoons, and surrounded by the endless ocean. However, these islands have far-reaching problems of economic depression and a pervasive sadness apparent to the reflective visitor to Micronesia. This comment is not to denigrate the hospitality of the people and the energy and determination of some individuals. What could have been regarded as the imperatives of subsistence gardening and fishing, with the need to build canoes, make nets and ropes, and prepare plots for taro and other staples, set the stage for a highly rational, and probably enjoyable, "work ethic". This has virtually disappeared and the non-adoption of a western-type work ethic means that, on a distribution curve basis, productivity is low and attention to detail is less than that necessary for an efficient health-care system, for a specific example. These facts are presented non-judgementally; they simply describe the situation and problems.

The physical environment itself seems to conspire against the technological equipment involved in health-care, communications, etc. The high temperatures, high humidity and salt-laden air destroy equipment at more than twice the rate "we" are accustomed to and, as preventive maintenance is not part of the nascent work-ethic, the Islands are littered with carapaces of defunct equipment.

This program has been developed, with the support of this Committee, in a spirit of optimism by persons who are thoroughly familiar with the pessimistic scene just described. Their familiarity is the origin of several principles implicit in the program.

In Micronesia:

1. Keep it simple and it will work.

2. Keep it small and it can be managed without a non-existent cadre of managers.
3. Rely on regular transportation with Honolulu for essential equipment maintenance.
4. Teach clinical medicine which is independent of automated clinical laboratories, specialized technicians and their monitoring equipment.
5. Build a simple communications system.
6. Build a curriculum that meets the realities of both the output needs and the educational level of the student intake.

Nature of Program, Essentials

We have completed most of the preliminary work to train about 75 indigenous people of Micronesia and America Samoa over a 9-year period to provide acute primary care at an advanced level, to provide preventive medical leadership and to train and supervise other health workers. They will be designated by their governments as Medical Officers (MOs) as distinct from Medical Doctors (MDs), who have undergone a more rigorous training based on an extensive scientific background in regular medical schools. The approach to the M.O. training is based on a realistic appraisal that not enough of the indigenous people receive primary and secondary education adequate to prepare them for the work leading to the M.D. degree. (Those Micronesians and American Samoans who can qualify for admission to medical school will continue to be accepted at the John A. Burns School of Medicine (in Hawaii) under the extant vigorous affirmative action policy supported by an HCOP grant.)

Need. The proposal is to meet an emergent health manpower shortage resulting from the fact that most of the 35 existing Medical Officers in the region are rapidly approaching retirement age with no replacements in sight. The long-term benefits of the program are that the key health professionals will continue to be indigenous, which has extensive cultural and linguistic advantages and, perhaps most important of all, will provide a cadre of primary care health manpower which will be affordable by the relevant entities in future economic uncertainties, especially in those approaching independence. As indicated, we plan an output of 75 new M.O.s over a 9-year period, and consider that this cadre will suffice well into the next century when new and different arrangements may be possible. We would emphasize that we are conducting only this program, which will have a beginning and an end. We are not establishing a "school".

Micronesian and American Samoan Involvement

The seeds of the proposed training program were sown in 1980 in some informal conversations among University of Hawaii faculty and Micronesian health leaders. The latter (all M.O.s) were concerned about the issue of depletion by retirement and that the changes in their own former school in Fiji (since Fijian independence), had made it extremely difficult for Microneisans to be admitted. By that time, the Fiji School of Medicine was oriented to the M.B.B.S. degree (the British equivalent of the basic U.S. M.D. degree), and not to be educating M.O.s.

From the beginning, the University of Hawaii faculty worked very closely with the Micronesian leadership and this extended into the regular legislative leadership, especially in the Federated States of Micronesia. As noted, these exchanges were formalized in 1984 by setting up an Advisory Board which included the health care leadership (identified by the Chief Executive Officer of each entity) and University of Hawaii faculty with extensive experience in Micronesia.

Through their representation on the Advisory Board, the various governments will "sponsor" applicants with an implicit commitment to employment as a Medical Officer if accepted and they graduate. It is immediately clear that there is no way of "enforcing" such a commitment because administrations and Health Directors come and go, but we will arrange that each letter of sponsorship include such a commitment. Further we expect that the number of sponsorships from each jurisdiction will reflect their perceived need. The actual selection committee is 50-50 University of Hawaii faculty and M.O.s drawn from the Advisory Board.

The Advisory Board has already agreed upon a 4 year training program followed by a mandatory 5th year of internship; the latter to be conducted in the home jurisdiction.

The details of the training have been developed from broad examinations of program development and implementation, including among others, cultural and linguistic implications for education, methods of instruction, screening and selection of students, and breadth and depth of material to be covered. These extensive discussions were carried out in a series of day-long conferences convened by the Dean of the University of Hawaii Medical School in September and October, 1984. The conferees were all noted for flexibility of educational philosophy and familiarity with the "problems" and they included Medical Officers now in responsible executive positions.

The outcome of these meetings is incorporated in the following description of the Philosophic Basis of Program Design.

Philosophic Basis of Program Design

The following overlapping areas were identified by the consultants and Advisory Board as crucial to program design. By the conventional patterns of planning, those at the top of the list are "soft" and intangible, while those towards the bottom of the list are "real" and might be conventionally considered the most difficult. We would emphasize that we early realized that the list as presented is in descending order of difficulty or, stated differently, the likelihood of serious and possibly irreversible mistakes are associated with items at the top of the list. Those lower in the list are items to be dealt with by familiar, matter-of-fact problem solving techniques.

1. There are intricacies and contradictions inherent in the overlay of an "official" (U.S.-type) hierarchy on a clan system in Micronesia with caste-like characteristics that long pre-dates western incursions, and is more "real" than any Table of Organization or objective selection system.
2. The cultures differ among the political entities and so we are not dealing with a homogenous set of socio-cultural milieux into which a training program can be fitted, nor can the graduates be equally effective in all loci. Furthermore, although the political divisions are along approximately linguistic and cultural lines, there are exceptions.
3. The traditional Micronesian attitude towards knowledge (information) is different from that of western educators. The traditional Micronesian view is that knowledge is finite in extent, unchanging in its content, is "secret", is conveyed by the master to a chosen pupil, and can become ineffective if misused or transmitted to "unauthorized" persons. This extremely traditionalist viewpoint has been much modified by the spread of western education, but is still evident in the astonishingly traditional navigators and they have youthful apprentices. Interestingly, however, western medicine has retained some comparable priestly exclusivity, and we consider this to be an asset.
4. It is a cold clinical fact that primary and secondary education in Micronesia has serious defects, and that even after two years at the Community College of Micronesia the average graduates of that select population read at the 9th or 10th grade level. Furthermore, related defects in the struggling educational system lead to an emphasis on memorization and little attention to the development of conceptual thinking, which can be used as a framework for complex factual information—as in medicine. Therefore, curriculum design has to be approached with all of this in mind, but not by just presenting a

"simpler" medical curriculum. Those senior medical officers (who had been trained in Fiji) who were party to these planning sessions were particularly emphatic about some of the irrelevant and demoralizing elements of the curriculum they had followed.

5. One could expect a reactive period of almost "exaggerated" separation among the entities before realities and necessities bring them into virtually automatic cooperation on projects such as the training of M.O.s
6. Pohnpei Hospital will be the focal site and the first two years of training will be conducted there and this will have an impact on hospital operations in the general sense and because part of the hospital will be used as a didactic training area. A former construction camp on hospital grounds will be refurbished to provide domiciliary and further training quarters.
7. There are insufficient patients in Pohnpei for clinical teaching in hospital wards. Therefore, other hospital facilities will need to be utilized. At least one limiting factor will be the cost of extra faculty to supervise students away from Pohnpei Hospital, especially in the early part of their clinical training (year 3).
8. The class size was extensively discussed and working backwards from a total output of 75 M.O.s, classes of 15 (with 20 admitted) were decided upon.
9. Housing is in very short supply in Pohnpei and it will be necessary to construct 3 "western-type" houses for on site faculty and their families and a similar (4th) structure to house faculty in Pohnpei for periods of a few weeks only, and without their families.

The special issues listed above were incorporated into the program design as follows:

1 and 2 Subtle Cultural Factors)

a. The sponsoring of the participating governments will ensure a pool of culturally appropriate candidates from whom a selection committee (including Micronesians) will then choose students on the "conventional" bases of character, learning aptitude, empathy and capacity to handle stress.
b. The "management" components of the curriculum will deal frankly with the necessity of a pyramidal hierarchical structure (as in an operating room, for example) and the need to keep the delicate issue of family status separate from health care imperatives.
c. In an exactly parallel way, the clinical training will emphasize the total

priority of the patient's well-being, regardless of the patient's social relationship to the health care professionals.

3 and 4 (Perceptions of Knowledge and Quality of Education)

a. As concession to the perception that knowledge is finite we have made about 200 common clinical entities the focus of the curriculum. Of course, this number is not really fixed or absolute, but can convey a "reassurance" that the body of knowledge to be mastered is indeed manageable.

b. For the earlier stages of training we have selected about 30 clinical entities which are representative of "clusters" of the larger number and can provide the vehicle for transmitting the core of basic science knowledge germane to an understanding of the disease entities and the scientific rationale of their diagnosis and treatment. An essential feature of this approach is that the student M.O.s will always have a clinically relevant focus for learning scientific material rather than being forced to learn the scientific material with only the faculty's assurance that they will later see its relevance.

c. Most medical textbooks are absurdly detailed even for the high-performance college graduates who are medical students in the U.S. We will assemble a list of those that are reasonably concise and, where necessary, ourselves generate suitable texts to fill the gaps.

d. Also, interactive computer assisted instruction has made very rapid strides and is a major project in the University of Hawaii School of Medicine. Accordingly we plan a facility for Pohnpei that will be totally compatible with that in Hawaii. We plan to transport soft ware as needed and do not plan real-time satellite transmission of such materials. Further, the technology of laser video-disc has made enormous progress and is particularly suited to those parts of medical education that are highly visual, such as histology, neuroanatomy, hematology, parasitology, etc. The crucial point here is that a slow reader is under no disadvantage in these learning modalities.

e. We have a tried and true basis for curriculum design

   i. What is the problem?
   ii. What needs to be done to handle the problem?
   iii. What needs to be learned in order to do the things that will handle the problem?
   iv. How do we teach those things?

v. What then is the performance of the trainee in handling the problem?

It will be noted that both computer assisted instruction and the curriculum design principle just described are just as applicable to management techniques and community health development as to the treatment of disease and the scientific basis thereof.

5. Intergovernmental Coordination

The Advisory Board carries out many coordinative functions but there is also a need for a "lead agency" in Micronesia. The University of Hawaii will certainly run the educational venture, but the FSM Department of Health Services will deal with other governments as the FSM will be the most impacted by the conduct of the program and has the greatest need with respect to outcome.

6. Pohnpei Hospital as Focus

a. Pohnpei Hospital will shortly become a teaching hospital and we have been developing clear understandings about the roles of faculty and trainees in the day-to-day operations (of the kind that exist now). Fortunately, the presence of the trainees will not become a major issue until the latter part of the second year of the program, and there will be plenty of time to develop policies in the light of experience. Nevertheless, the presence of highly qualified, full-time University of Hawaii faculty will greatly strengthen the hospital, but a balance must be struck between their educational responsibilities (even those involving patients) and the natural tendency to regard them as "extra" clinicians. Again, the planning group felt that it is premature to work on detailed expectations in this context.

b. Because of some changes in the hospital's functions since the time it was planned, there is a ward which can be used as a study hall, library and repository of the C.A.I. materials and equipment. This has some attractions for security of valuable equipment as well as a good utilization of existing resources.

c. A recently disused construction camp (for road building) lies on hospital grounds across the road from the hospital proper. The assignment of this to the M.O. program has been approved by the Government of Pohnpei. A DHHS grant for the program permits expenditures for refurbishment and remodeling, which is proceeding.

d. We have arranged for the hospital to provide cafeteria food service to the M.O. students by contract.

7. Patients for Clinical Teaching

This is another problem area that we feel will largely solve itself as the program moves along. Those governments with several students in training will want those students to have clinical experience in their home jurisdictions—as will the students themselves. As noted, the cost of supervisory faculty will make it necessary to use as few facilities away from Pohnpei as possible.

8. Class size

a. The planning group has a consensus that 20 with an expected attrition of 5 is a reasonable number for the first class. This can be adapted as we get experience of attrition expectations.

b. The Micronesian leadership were unanimous about the following:

    i. Anyone sponsored by their government may apply but there was great concern about the "loss" of existing health personnel (such as Medex) by this route.

    ii. It followed then that the original idea of perhaps having one or two initial classes made up entirely of experienced health professionals was emphatically disapproved.

c. The "standard" entry pattern will be after about a seven quarter program at the Community College of Micronesia (CCM). This has been discussed extensively with the leadership of CCM with respect to the suitability of the program (as preparation for the M.O. program) and also that the CCM program will award their usual A.A. diploma to the inevitable majority of the aspirants who do not get accepted to the M.O. program.

d. It is further recognized that there are other young Micronesians who have attended other institutions (than CCM) and may even have baccalaureate degrees. All of these would be considered; we do not plan an exclusive lock-step with CCM.

9. Faculty Housing

The F.S.M. Government has negotiated with their Development Bank a loan for the construction of 4 houses adjacent to the hospital. The Government will be the mortgagee, and the loans will be amortized by rent paid by our faculty (as individuals) to the F.S.M. Government. Nothing in this arrangement will affect the grant from DHHS.

Clinical Curriculum

The curriculum of this program designed to train Micronesian Medical Officers in Pohnpei is based on a set of goals and objectives. The format borrows heavily from the published curricular objectives of Southern Illinois

University School of Medicine, but the content has been, and will continue to be, modified to meet the needs the medical officers will encounter in actual practice. Wherever possible "The student will be able to ..." is the implied beginning of each objective.

The content of the clinical material the student will learn is based on a series of clinical problems the student will encounter in later practice. The problems are stated most simply as chief complaints, which in turn direct the student in gathering appropriate information to formulate a problem or set of problems and to proceed with a plan for solving them.

The Micronesian Medical Officer needs to acquire competency in primary health care. The definition of primary health care in this context is all health care available on site—in each of the separate islands where the doctor finds himself. It is necessary to include the management of many dire, life threatening emergency problems including stabilization and preparation of patients for air transportation where appropriate and available, but often the total management of an emergent problem. Clearly this will require much more sophisticated skills (and confidence) than the traditional primary care definition implies.

Basic Sciences

The basic sciences will be taught in the context of patient problems; not as a separate discipline, but as an integral part of clinical instruction.

We propose that a detailed study of human anatomy go along with a carefully selected series of clinical topics from the very beginning. The cadaver will provide the focus of the discussion, including especially the physiology and pathophysiology of the organ systems. We have concluded that a thorough familiarity with the structures and functions of the human body will provide a rationale (to the students) for ordinary class-room discussions of enzyme systems, fluid and electrolyte balance, etc., as well as later discussion of pathological processes.

Out of respect for the insurmountable Micronesian attitudes towards the dead, the 5 cadavers per class will be provided from the University of Hawaii, which has a well-supported donor system. This decision regarding cadaver dissection will require good security and air conditioning.

Note: It may be noted that the original M.O. training used cats for anatomy teaching; a fact recalled as relatively useless by those M.O.s on our advisory committee.

Health Promotion and Disease Prevention

The student will learn these aspects of health care in the context of patient problems. Emphasis will be placed on:

Communicable diseases
Maternal care
Child health nutrition
Accidents
Village and home sanitation
Community development

If a curriculum is to be based on specific goals and objectives, these goals and objectives must be closely tailored to the needs of the community of people the physician will serve. These needs are very well identified in Micronesia, and often differ quite markedly from the needs of American communities. The physician for the Micronesian community must be trained to meet these needs with emphases quite different from standard American education.

Certain clinical problems that command attention in Micronesia, not only in terms of their prevalence, but of their importance to the daily life of the inhabitants and the relatively simple means of their prevention and treatment merit strong emphasis in a curriculum for Micronesian Medical Officers. Identification of these problems is not difficult. Mortality and morbidity reports over the years, the experience of seasoned Micronesian practitioners involved in the development of this training program, and the experience of University of Hawaii School of Medicine faculty in consulting, teaching and providing locum tenens in Micronesia provide a consistent picture.

A short list of problems needing special emphasis in the curriculum includes:

1. Infectious disease. Tuberculosis and leprosy are commonly encountered diseases capable of being controlled and prevented without sophisticated technology. Tuberculosis is the major diagnostic consideration in patients presenting with problems that in the metropolitan United States would indicate investigation for brain or abdominal cancer. Both tuberculosis and leprosy can be virtually eliminated if doctors are well and thoroughly trained to recognize and deal with it. Local education will result in far better trained doctors than those coming from U.S. institutions, where these diseases are given scant attention, almost as medical curiosities.

   Intestinal parasitism is near universal and in a medical work up of a patient with any abdominal complaint, bowel obstruction for example, parasitism must be considered the cause until disproven. These problems are almost entirely preventable.

Otitis media in children is rampant, and the tragic sequelae of draining ears and deafness lead to learning disabilities on a scale unimaginable in modern times. The Micronesian doctor needs to know far more than his American colleague about its diagnosis and management.

Bacterial diarrhea--particularly in children who so easily enter a state of profound dehydration and electrolyte imbalance is another example of diseases with unexpected importance.

Filariasis with chylous ascites is virtually unknown in temperate zone America, hence disregarded in medical school teaching, but is encountered again and again in Micronesia.

Skin diseases, often the result of infection, constitute a large part of Micronesian clinical practice. If the Micronesian doctor were an excellent dermatologist and nothing else, he or she would still be a valued member of the medical service.

2. Genetically determined disease. Late onset diabetes reaches extraordinary high prevalence in selected Micronesian populations. Diagnosis and management is achievable locally if the physicians have the appropriate skills, knowledge and attitude. Obesity and hypertension are certainly important problems that may fall partially in this category.
3. Trauma. Generally, mechanical injury is the most important aspect of training, increasing as motor vehicles become more common and better roads allow more than a snail-like pace. Lacerations and head injuries are common weekend phenomena, while burns are rare.
4. Mental health. The number of suicides is an alarming figure in some of the cultures of Micronesia. Physicians must learn--in fact may have to be the ones to discover—the underlying factors and their management.

MEDICAL OFFICER TRAINING PROGRAM FOR MICRONESIA AND AMERICAN SAMOA

Executive Summary

The purpose of the program is to train indigenous people of Micronesia and American Samoa to deliver acute primary health care at a very advanced level, to provide preventive health leadership, to train and supervise other health workers. We propose to admit 5 classes of 20 students of which we expect 15 in each class to survive attrition. The course will be 5 years in duration, during which time the student Medical Officers will learn to diagnose and treat all but the most complex clinical problems, including, when necessary, the management of trauma and obstetrical exigencies requiring surgery if in a remote location. The yield of the program will be 75 new Medical Officers over a nine year period, at which point it will be discontinued. The objective is to provide a new cadre of M.O.s to replace the current ones who will be nearly all retired by 1990 and thereby diminish the need for costly expatriate M.D.s who are currently mainly engaged in primary care.

All trainees will be indigenous Micronesians and American Samoans, sponsored by their governments at the time of application, with a commitment to subsequent employment if accepted and graduated. Actual selection will be made by a joint committee of University of Hawaii School of Medicine faculty and Micronesian and American Samoan Health leadership. The main-stream of applicants will be graduates of a community college in Micronesia with an average reading level of Grade 10, although students with other academic backgrounds will be considered.

The main base will be at Pohnpei State Hospital in the Eastern Caroline Islands. One ward of the hospital will be used as a library, study-hall, etc., and a nearby former construction camp will be used for laboratories, classrooms and housing for the students. All of these facilities are on hand and in good condition. They only need refurbishment and modifications to conduct the program. The main instructional staff will be University of Hawaii faculty based semi-permanently on Pohnpei, U.H. faculty for up to one-month visits and senior Micronesian Medical Officers on temporary assignment by arrangement. Introductory clinical instruction will be conducted in the wards of Pohnpei Hospital, and so will advanced instruction to begin with. As the advanced student population grows, it will be necessary to include the teaching facilities (probably in Truk and the Marshalls) and to locate U.H. Directors of Education at those loci.

MEDICAL OFFICER TRAINING PROGRAM FOR MICRONESIA AND AMERICAN SAMOA

This testimony comprises a progress report on the Medical Officer Training Program for Micronesia and American Samoa resulting from an appropriation which was initiated by the recommendations of the Subcommittees. Although the appropriation was made in FY 1985 (PL 98619), the award of a $2.5 million grant from the Department of Health and Human Services (D.H.H.S.) was not received until January, 1986. The Office of Management and Budget delayed the necessasry apportionment of funds. During this delay, we were much encouraged by the tangibly supportive attitude of the Officers of the D.H.H.S. (who had by then approved our proposal).

Nevertheless we had received a $120,000 planning grant from the Department of Interior which permitted considerable preliminary work to be conducted, including the setting up of an Advisory Committee with membership drawn from the health leadership of the Micronesian Governments, American Samoa, and the University of Hawaii.

Extensive curricular planning was undertaken based on the essential professional knowledge and skills, and upon the realities of the educational level of the trainees expected, and their culturally-induced attitudes towards knowledge and learning. Formal planning and negotiations with the participating governmnts were deliberately delayed until receipt of the D.H.H.S. grant since we realized that that would focus their attention on the project as an immediately viable program. Nevertheless, the prior informal discussions had been immensely useful because, in literally one week in February, 1986, a series of detailed negotations were completed with the Federated States of Micronesia (FSM), the State of Pohnpei, and the Pohnpei State Hospital which will be the main locus of the program. These involved legal issues regarding our formal affiliation with the hospital, a free 10-year lease of a former construction camp for use as dormitories and classrooms, the matter of "local-hire" employees, and professional liability indemnification; these matters could have been expected to require months of negotiation had they been approached "cold". The D.H.H.S. grant provides for up to $300,000 for the one-time renovation and remodeling of the construction camp buildings, and the engineering and architectural preliminaries to that are underway as this report is prepared. It may be noted that we have also received enthusiastic cooperation from a Community Action Team of the U.S. Army Corps of Engineers based on Pohnpei.

We will hold a meeting of the Advisory Committee in June and a major agenda item will be the nomination, by participating governments, of candidates to be admitted to the program. The class itself will be selected by a committee of University of Hawaii faculty who will be intimately involved with the program and some Micronesian Medical Officers who will also be involved with the teaching program.

We expect to begin the training of the first class in September 1986 since they will not exceed 20 in number and can be accommodated (physically and academically) while renovations, etc., are still in progress. Should there prove to be major problems, our fall-back starting date would be in January, 1987 to keep the program synchronous with the rhythm of the academic year of the Community College of Micronesia, which we anticipate will be the main "feeder" institution.

TUESDAY, APRIL 29, 1986.

NATIONAL INSTITUTE OF ARTHRITIS MUSCULOSKELETAL AND SKIN DISEASES

WITNESS

DR. ROBY THOMPSON, PRESIDENT, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Mr. NATCHER. Our next witness is Mr. Roby Thompson. Dr. Thompson, we will be pleased to hear from you at this time.

Dr. THOMPSON. Thank you, Mr. Chairman, Congressman Conte, I am Roby Thompson, head of the Department of Orthopaedic Surgery at the University of Minnesota and President of the American Academy of Orthopaedic Surgeons, 12,000 members who specialize in training and medicine, has been concentrated on the diseases and disorders of the musculoskeletal system.

These conditions afflict 32,000,000 Americans and span our lives from birth defects such as CDH and spina bifida, to up to 200,000 hip fractures per year in women with osteoporosis.

Between these extremes are the developmental conditions such as scoliosis or spinal curvatures, accidental injuries from falls and motor vehicle accidents, and sports, and the plague that hits almost all of us over 40 years of age, low back pain.

You will hear more about arthritis from my colleagues later today. However, in spite of valiant efforts to control the destruction of joints in the body by a variety of treatment programs, a substantial number of Americans continue to be crippled with destroyed joints that can only be managed by surgical means.

The most dramatic clinical advances in this area has been joint replacements. Even though the initial successful joint replacements were designed in Europe, the advances of the past 10 years have been largely based on the results of fundamental research performed in this country with the assistance of NIH funding.

In my opinion, these advances will dramatically reduce the need for revision surgery of replaced joints in the future. There have been many other dramatic improvements in patient care directly related to the wisdom of the Congress in appropriating funds for the NIH.

Some that stand out are those basic studies on ligament and tendon injuries, how they heal, how to provide the fastest recovery from injury and the most lasting result of treatment.

I would like to add the endorsement of the orthopaedic community for the specialized centers of research in arthritis and osteoporosis. The science base in these areas is now near the "critical mass" and this mechanism would encourage the concentration of key personnel and resources.

The orthopaedic community understands the budgetary restraints this inaction requires; yet we believe that the appropriations we have requested in our written testimony are reasonable and represent a sound investment in the future of our economy, that will provide us with the healthy citizens of all ages, necessary for the independent lifestyle characteristic of this Nation's great history.

Thank you, Mr. Chairman. I will be happy to answer questions if you have any.

Mr. Natcher. Thank you very much, Dr. Thompson. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Dr. Thompson follows:]

STATEMENT OF THE
AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS
on the
FY1987 APPROPRIATION FOR THE
NATIONAL INSTITUTE OF ARTHRITIS, MUSCULOSKELETAL, AND SKIN DISEASES
to the
HOUSE LABOR/HHS/EDUCATION SUBCOMMITTEE ON APPROPRIATIONS

PRESENTED BY
ROBY C. THOMPSON, M.D.
April 29, 1986
10:30 A.M.

Mr. Chairman and members of the Committee, I am Roby C. Thompson, M.D., Chairman of the Departments of Orthopaedics and Physical Medicine and Rehabilitation at the University of Minnesota and President of the American Academy of Orthopaedic Surgeons.

I am pleased to appear before you today to present the Academy's position on the need for continued and, if possible, expanded funding of research programs on the musculoskeletal system at the National Institute of Arthritis, Musculoskeletal and Skin Diseases. The Academy is a fellowship organization, with over 12,000 Board certified orthopaedic surgeons. One of its major objectives is to foster, develop and support investigative knowledge of orthopaedic surgery and the prevention of disorders of the musculoskeletal system.

The musculoskeletal system makes up over 70 percent of the body. Its unique tissues are welded into functional units of bones, joints, muscles, tendons, ligaments, nerves, and skin. This system provides for our physical function and our ability to perform the tasks of everyday living.

Musculoskeletal diseases afflict an estimated 32 million Americans and account for over $65 billion in medical expenses and lost earnings each year. These diseases and disorders affect all age groups. For example:

* Osteoarthritis -- the result of wear and tear on joints of the body -- afflicts more than 16 million Americans and markedly diminishes the quality of life.

* Osteoporosis -- loss of bone mass -- affects over half of all women above the age of 45. This condition is considered the leading factor in the 200,000 hip fractures women suffer every year. The costs associated with osteoporosis amount to over $6 billion annually.

* Rheumatoid arthritis is a chronic inflammatory disease affecting both small and large joints, causing pain, immobility, and severe skeletal deformity. The costs associated with arthritis amount to over $8 billion annually.

* Birth defects, spina bifida, scoliosis, and brittle bone disease (osteogenesis imperfecta) are just some examples of crippling disorders which strike during infancy and childhood.

- Fractures and injuries to the muscles, ligaments, and tendons in otherwise healthy Americans of all ages resulting from accidental falls, motor vehicle accidents, and sports related injuries.

- Low back pain will affect 80% of all individuals during their lifetime. It is the major cause of limited activity under age 45, accounts for one-sixth of all occupational injuries, and is responsible for almost $16 billion in economic costs annually.

- Bone cancer accounts for a small percentage of primary malignancies, but bone is a common and painful site of metastasis when cancer spreads.

The investment of government funds in musculoskeletal diseases research over the past two decades has resulted in substantial payoff to the taxpayers, and more importantly to those individuals afflicted with these diseases. One of the most significant accomplishments has been in the area of destroyed joints from any cause, through the use of artificial implants. Even though the original successful human joint replacements were largely developed in Europe, NIH-sponsored research has resulted in new designs and surgical techniques which have greatly improved the durability and longevity of these implants.

Other major advances in patient care as a result of federal funding for basic research in musculoskeletal research:

- * Studies on ligament injuries, their healing response and ways to improve the results of management for patients with these injuries. These studies have improved the results of these joint injuries with better joint motion at an earlier stage and a more stable joint over the long term.

- * Improved understanding of the care of the multiply injured patient with earlier stabilization of fractures leading to improved survival and better function.

- * Development of new technology to allow management of fractures that shortens hospital stay - decreases complications of injury and allows earlier return to functional status.

Mr. Chairman, basic research is the lifeline of improved patient care. Each new bit of information, added to the existing scientific data base, contributes to the clinical advances and the alleviation of human suffering.

There are a large number of scientific areas that warrant intensive investigation, and the following are but a few of the promising areas:

1. Research on the causes of osteoarthritis, its pathophysiology, and better methods of improving function in the diseased joint to include cartilage grafts and control of cartilage remodeling.

2. Research on joint injuries that often lead to premature arthritis.

3. Research on bone diseases such as osteoporosis, which weakens the skeletal support mechanism to determine the effects on genetic predisposition, diet, hormones, and environment on the severity and incidence of these diseases.

4. Basic research to develop better design, materials, and fixation techniques for joint replacements and other skeletal implants.

5. Research on the pathophysiology of back pain in order to provide a rational approach to decrease the impact of this major disorder of society.

6. Research on the basic healing mechanisms for bone, ligaments and tendons in order to allow for optimum treatment and rehabilitation following injury or disease.

7. Research on the application of transplants for bone and other connective tissue to determine acceptability, application, and ways of improving their utilization to replace missing segments of the skeleton and its support structures.

Specialized Centers of Research

Mr. Chairman, research in the areas of osteoarthritis, rheumatoid arthritis, and osteoporosis have progressed to the point where a concentrated multidisciplinary research effort should be initiated. A successful mechanism used by many of the NIH Institutes to provide a highly effective means of concentrating research personnel, resources and facilities on diseases of national importance is the "Specialized Centers of Research".

These specialized centers of research provide a valuable compliment to an Institute's portfolio of investigator-initiated research projects. This mechanism provides an institute with the means of stimulating wider research interest in selected high priority areas, and more importantly, these centers insure that adequate support is provided for clinically oriented basic science and its application to clinical problems.

Mr. Chairman, we respectfully urge the Committee to set aside funds at a level of $7.6 million for at least nine specialized centers of research, 3 in each of the major disease areas -- osteoarthritis, rheumatoid arthritis, and osteoporosis. These diseases afflict the fastest growing segment of our population, namely, those individuals over 50 years of age. Unless we take advantage of the research opportunities now before us, the frequency of occurrence and impact of musculoskeletal conditions will become greater in the future.

1987 Budget

The efforts of this Committee to maintain the momentum in science and its attempts to bring hope to those individuals suffering from disease, are severely cut in the 1987 President's budget. While we fully appreciate the difficult fiscal conditions under which you are operating, we believe, like Emerson, that "Health is the first wealth", and thus the government must provide for sound health of its citizens today and into the future. It is with this in mind, that we respectfully urge this Committee to provide $151,650,000 for the National Institute of Arthritis, Musculoskeletal, and Skin Diseases.

Mr. Chairman, I want to thank you and the members of the Committee for the past support of biomedical research and in particular, the research program on musculoskeletal diseases. I will be happy to answer any questions.

TUESDAY, APRIL 29, 1986.

NIAMSD

WITNESS

DR. ROBERT LINDSAY, NATIONAL OSTEOPOROSIS FOUNDATION AND AMERICAN SOCIETY FOR BONE AND MINERAL RESEARCH

Mr. NATCHER. Our next witness is Dr. Lindsay.

Dr. LINDSAY. Thank you, Mr. Chairman.

I would like to make this statement on behalf of the National Osteoporosis Foundation and the American Society for Bone and Mineral Research, and am pleased to submit a statement in strong support of the goals of NAIMSD.

The creation of a new Institute devoted to the study of the disorders of the musculoskeletal system and skin is, in itself, recognition of the impact of those various conditions on the health of our Nation's people.

The National Osteoporosis Foundation and American Society for Bone and Mineral Research urge that the NAIMSD become active as soon as possible.

Osteoporosis is one of the most significant public health problems to be addressed by the new Institute. It is an extraordinarily common condition in which excessive losses of bone tissue usually associated with aging yields an extremely fragile skeleton.

Fractures of the spine, resulting in loss of weight and a dowager's hump, fractures of the wrist, and fractures of the hip are its most typical manifestations, although fracture of any bone can occur.

Osteoporosis afflicts as many as 15 to 20,000,000 people in the United States, usually women, and causes over 1,000,000 fractures annually, including 250,000 hip fractures. It extracts an enormous toll in terms of suffering, mortality and financial cost.

Approximately 15 percent of elderly hip fracture patients will die within one year because of the fracture, and over 50 percent of the survivors will be permanently disabled, no longer able to live independently.

For many, hip fracture heralds permanent hospitalization in a long-term care facility. The cost of osteoporosis to our Nation is estimated at $6,000,000,000 each year, and that cost can be expected to expand because of inflation, and because of increases in our older population, the group that is most susceptible to osteoporosis.

It is not difficult to envisage the mounting destructive impact of osteoporosis as our society ages. Research initiated today may well serve to thwart this mounting public health problem in the future.

We feel that NAIMSD is in the best position to underwrite the urgent research strategies required to curb the heavy toll of osteoporosis. Some were recommended by the recent Consensus Development Conference on Osteoporosis, sponsored by the NIH.

Strategies to prevent the ubiquitous aging-associated postmenopausal bone loss, targeted to individuals at risk, are expected to culminate in prevention of fractures.

In brief summary, those recommendations included the following: One, basic, epidemiological and clinical studies to determine the mechanisms of and risk factors for osteoporosis and to predict responses to intervention.

Two, studies to expedite the improvement of existing methods for measuring bone tissue and for developing newer and less expensive approaches.

Three, studies to develop safe, effective and low cost approaches for preventing osteoporosis; and, four, studies to improve the management of individuals with established disease and the management of bone fractures.

NAIMSD is the Institute which the scientific community will call upon to support the vital basic and clinical research which will be required in order to prevent and treat this devastating disorder.

We urge that Presidential and Congressional support for NAIMSD be endorsed by the appropriation of funds at a level adequate to fulfill its anticipated goals. The Osteoporosis Foundation and the American Society for Bone and Mineral Research feel strongly that a concerted attack on osteoporosis is overdue.

NAIMSD will require a strong intramural program, and sufficient support to fund a significant quota of investigated initiated research proposal with a reasonable priority score payline.

Finally, adequate administrative personnel must be available for NAIMSD to function as an independent Institute.

The American Society for Bone and Mineral Research is the principal organization structure for the dissemination of scientific information in the field. Its current President, Dr. B. Lawrence Riggs, will chair its forthcoming eighth annual scientific Meeting of the Society in Anaheim, California in June 1986.

The National Osteoporosis Foundation is a newly established foundation which has established as its principal goal the education of the public and health professionals about osteoporosis and related metabolic bone diseases and to stimulate support for research and research training in the field.

The Honorable Paul G. Rogers is Chairman of its Board of Directors, and Dr. William A. Peck, who chaired the Consensus Development Conference on Osteoporosis, is its President, and Ms. Sandra C. Raymond its Executive Director.

This statement of strong support for NAIMSD is presented for and on behalf of both the scientific community and the Foundation.

Thank you for your indulgence.

Mr. NATCHER. Thank you very much, Doctor. You have made an excellent statement. We appreciate your appearance before the committee. It takes 12 to 14 weeks of hearing before we finish the Department's witnesses. We are very much concerned about what they say when they appear before this committee, Dr. Lindsay.

We are also very much concerned about what you say. I say each year to the outside witnesses, they travel thousands of miles to come here. It means a lot to us, and we are delighted to have you.

This is our country, and this is our money, and we need all the help we can get on this subcommittee. I say that to you frankly.

Dr. LINDSAY. Thank you very much, sir.

[The statement of Dr. Lindsay follows:]

Statement of the

NATIONAL OSTEOPOROSIS FOUNDATION

and

AMERICAN SOCIETY FOR BONE AND MINERAL RESEARCH

By

Robert Lindsay, M.D., Ph.D.

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Department of Medicine

Columbia University, College of

Physicians and Surgeons, NY and

Director of Research

Regional Bone Center

Helen Hayes Hospital

West Haverstraw, New York

Before the

Subcommittee on Labor, HHS, and Education

Committee on Appropriations

U.S. House of Representatives

April 29, 1986

10:40 A.M.

Statement of the
NATIONAL OSTEOPOROSIS FOUNDATION
Before the
Subcommittee on Labor, HHS, and Education
Committee on Appropriations
U.S. House of Representatives
with respect to the
FY 1987 Budget of NIAMSD, NIH

On behalf of the National Osteoporosis Foundation and the American Society for Bone and Mineral Research, I am pleased to submit a statement in strong support of the goals of NIAMSD.

The creation of a new institute devoted to the study of the disorders of the musculoskeletal system and skin is, in itself, recognition of the impact of those various conditions on the health of our nation's people. The National Osteoporosis Foundation and American Society for Bone and Mineral Research urge that the NIAMSD become active as soon as possible.

Osteoporosis is one of the most significant public health problems to be addressed by the new institute. It is an extraordinarily common condition in which excessive losses of bone tissue usually associated with aging yields an extremely fragile skeleton. Fractures of the spine, resulting in loss of height and a dowager's hump, fractures of the wrist, and fractures of the hip are its most typical manifestations, although fracture of any bone can occur.

Osteoporosis afflicts as many as 15-20 million people in the United States, usually women, and causes over 1 million fractures annually, including 250,000 hip fractures. It extracts an enormous toll in terms of suffering, mortality, and financial cost. Approximately 15% of elderly hip fracture patients will die within one year of the fracture and over 50% of the survivors will be permanently disabled, no longer able to live independently. For many, hip fracture heralds permanent hospitalization in a long-term care facility. The cost of osteoporosis to our nation is estimated at $6 billion each year, and that cost can be expected to expand because of inflation, and because of increases in our older population, the group that is most susceptible to osteoporosis. It is not difficult to envisage the mounting destructive impact of osteoporosis as our society ages. Research initiated today may well serve to thwart this mounting public health problem in the future.

We feel that NIAMSD is in the best position to underwrite the urgent research strategies required to curb the heavy toll of osteoporosis. Some were recommended by the recent Consensus Development Conference on Osteoporosis sponsored by the NIH. Strategies to prevent the ubiquitous aging-associated postmenopausal bone loss, targeted to individuals at risk, are expected to culminate in prevention of fractures. In brief summary, those recommendations included the following (1) Basic, epidemiological and clinical studies to determine the mechanisms of and risk factors for osteoporosis and to predict responses to intervention; (2) studies to expedite the improvement of existing methods for measuring bone tissue and for developing newer and less expensive approaches; (3) studies to develop safe, effective, and low cost approaches for preventing osteoporosis, and (4) studies to improve the management of individuals with established disease and the management of bone fractures. NIAMSD is the institute which the scientific community will call upon to support the vital basic and clinical research which will be required in order to prevent and treat this devastating disorder.

We urge that Presidential and Congressional support for NIAMS be endorsed by the appropriation of funds at a level adequate to fulfill its anticipated goals. The Osteoporosis Foundation and the American Society for Bone and Mineral Research feel strongly that a concerted attach on osteoporosis is overdue. NIAMS will require a strong intramural program, and sufficient support to fund a significant quota of investigated initiated research proposals with a reasonable priority score payline. Finally, adequate administrative personnel must be available for NIAMS to function as an independent institute.

The American Society for Bone and Mineral Research is the principal organization structure for the dissemination of scientific information in the field. Its current president, Dr. B. Lawrence Riggs, will chair its forthcoming 8th annual scientific meeting of the society in Anaheim, California in

June, 1986.

The National Osteoporosis Foundation is a newly established foundation which has established as its principal goal the education of the public and health professionals about osteoporosis and related metabolic bone diseases and to stimulate support for research and research training in the field. The Honorable Paul G. Rogers is Chairman of its Board of Directors and Dr. William A. Peck, who chaired the Consensus Development Conference on Osteoporosis, is its president and Ms. Sandra C. Raymond, its Executive Director.

This statement of strong support for NIAMS is presented for and on behalf of both the Scientific Community and the Foundation.

TUESDAY, APRIL 29, 1986.

NIAMSD

WITNESS

ROBERT C. HOLLENBACH, GOVERNMENT AFFAIRS COMMITTEE, ARTHRITIS FOUNDATION

Mr. NATCHER. Mr. Hollenbach, we are delighted to have you before the committee, and we will be pleased to hear from you.

Mr. HOLLENBACH. Thank you, Mr. Chairman, and members of the committee. My name is Robert Hollenbach. I am a volunteer member of the Arthritis Foundation, Metropolitan Washington Chapter. I am presently Chairman of the Metropolitan Washington Chapter Education and Community Services Committee, and a member of the Chapter Executive Committee and Board of Directors.

I also serve on the National Government Affairs Committee of the Arthritis Foundation, the national voluntary health organization with 71 chapters and divisions throughout the United States. It is in behalf of the national Arthritis Foundation that I appear today. In their behalf, I would like to thank the committee for this opportunity to testify.

The interest of the Arthritis Foundation in appropriations for the National Institute of Arthritis and Musculoskeletal and Skin Diseases, NAIMSD, derives from its commitment to the more than 38,000,000 Americans who have arthritis.

Research and training supported through this newest NIH Institute has direct and profound effects on our population with arthritis.

As this committee knows, NAIMSD was created on November 20, 1985, enacted into law as part of the Health Research Extension Act, H.R. 2409. Members of this subcommittee supported through your votes the establishment of the new research institute.

This budget year, fiscal year 1987, marks the first opportunity for Congress to fund the Institute you created last fall. We are confident you will want to insure that appropriations for the new Institute are adequate to establish it as a fully functioning entity, able to initiate the focused attack on arthritis you intended at the time of its enactment.

The Arthritis Foundation endorses the fiscal year 1987 NIH wide funding level proposed by the Ad Hoc Group for Medical Research Funding as the absolute minimum necessary to maintain biomedical research momentum in this country.

The amount proposed, $6,100,000,000, is a conservative recommendation and is only 1.4 percent above current service levels.

For the National Institute of Arthritis and Musculoskeletal and Skin Diseases, we urge Congress to accept the funding recommendations of the NAIMSD Coalition, a recently formed confederation of voluntary health organizations, professional societies, and consumer groups concerned with arthritis, bone and skin disease research.

The Arthritis Foundation and the Coalition concur that $151,650,000 is the minimum amount necessary to preserve the research integrity and the organizational stability of the new Institute. We offer for the record a statement endorsed by the Coalition organizations.

Specifically, we believe the allocation of $100,000,000 for investigator-initiated research grants is a necessary minimum level for fiscal year 1987. This amount, only about 3 percent over current services, would enable NAIMSD to fund 24 additional new grants and bring the award rate up to about 34 percent of approved grants, with a priority score of 170.

This is far below the NIH average of the last decade, but would be an improvement over the last few years, nonetheless.

Last year, the Arthritis Foundation urged this committee to fund Specialized Centers of Research in three target areas. This committee's report on the fiscal year 1986 appropriation bill for Labor, HHS and Education endorsed the SCOR concept applied to the arthritis field.

The report states:

"Specialized Centers of Research, SCOR, are useful mechanisms for accelerating research in areas where coordinated, multidisciplinary efforts are likely to produce rapid clinical applications of basic science advances.

"There are several promising areas of research in arthritis and musculoskeletal diseases which might benefit from the SCOR concept of integrating basic and clinical research in one setting, including rheumatoid arthritis, osteoarthritis and osteoporosis.

"Research in these areas has advanced to the point where a concentrated multidisciplinary research effort could be initiated. The committee continues to be concerned about the need to strengthen the arthritis and musculoskeletal diseases research program, and therefore, encourages the Institute to explore the feasibility of establishing Specialized Centers of Research in these high-priority areas.

"The committee will expect a report on this matter before next year's hearings."

The Institute has not the resources to divert to such a program, no matter how important and desirable. Therefore, new funding is essential to initiated targeted, multidisciplinary research through SCORs.

We believe NAIMSD is prepared to move quickly to establish SCORs in three of the greatest national health problem areas confronting that Institute: Rheumatoid arthritis, osteoarthritis and osteoporosis.

Each of these target diseases be addressed by three SCORs; each would complement, and be complemented by, investigator-initiated research projects.

SCORs represent an exciting new approach to accelerate our scientific knowledge in arthritis and bone disease fields, and we are convinced that support from Congress in the amount of $7,650,000 for this purpose would be money well spent.

A report recently submitted to this committee by NIH, entitled "Specialized Centers of Research in Arthritis and Musculoskeletal Diseases" strongly endorses SCORs provided new funding is made available.

The Arthritis Foundation is deeply concerned by the erosion in support for research training. Unless funding is increased, no new Clinical Investigator or Physician Scientist Awards would be available in fiscal year 1987.

Without training for an adequate number of new and established scientists, we will discover within a few years that the cutting edge of biomedical research will have been irretrievably lost, along with this Nation's preeminence.

We urge appropriations of $7,800,000 to strengthen "other research," which supports research career awards, Clinical Investigator Awards, and Physician Scientist Awards, and $6,130,000, the current services level, for National Research Service Awards.

Multipurpose Arthritis Centers have been inadequately funded over the past few years, despite this committee's efforts to maintain them at high levels. The number of centers has dwindled from 21 to 14, and their grant awards have been reduced each year due to limitations on available funds.

An appropriation of $11,909,000 would fully fund the existing centers at current service levels. We urge the committee to provide at least this amount.

Research management and support, the administrative expense account, urgently needs your attention if the new NAIMSD is to be a fully functional entity. Already administratively lean in comparison with other NIH research institutes, NIADDK as formerly constituted and currently staffed cannot support two Institutes.

35 intramural and 14 extramural support slots are now assigned to NAIMSD. Another 36 positions are necessary for the operation of the new Institute, at a cost of $1,500,000 above the President's budget.

Many exciting avenues of research are underway in the arthritis field, as NIH witnesses previously have testified. In rheumatoid arthritis, a specific parvovirus, RA-1, is strongly suspected of precipitating immune responses which result in disease.

Use of a hybrid animal model, the MRL/1 mouse, has led to the exciting etiologic implication that some cartilage destruction precedes joint inflammation, instead of the other way around, as previously thought.

In the area of treatment, a cancer fighting cytotoxic drug, methotrexate, is found to be effective in reducing rheumatoid arthritis.

Systemic lupus erythematosus, SLE, is the subject of intense research efforts, including the use of monoclonal antibodies, to better analyze the disease process and identify genetic predisposition to the disease.

Intramural scientists have determined that lupus in mice can be controlled or eliminated by the insertion of a specific protective gene.

Osteoarthritis is another area of heavy research concentration, since some 16,000,000 Americans have this form of the disease. It is clear that osteoarthritis is not merely a "wear and tear" ailment of older persons, but involves protein factors which cause abnormal behavior in cartilage cells.

Last year, the NIADDK Arthritis Division held a comprehensive workshop on osteoarthritis, which will give further direction to promising areas of research.

Because of the paucity of past funding for arthritis research at NIH, understanding of many of the rheumatic diseases is little more than superficial. We are confident that with a concerted attack, many of the answers may be found in the not too distant future.

We are able to treat and ameliorate the progression and disability of some of the arthritides but have not yet found a care for any of them. The Arthritis Foundation believes that funding at the levels and in the areas we recommend will bring profound changes in a range of scientific inquiry relating to arthritis.

The total funding recommended by the Arthritis Foundation for NAIMSD is $151,650,000, only $18,400,000 more than the estimated current services level of $133,250,000. The National Arthritis Advisory Board has indicated to you in its testimony, as a reflection of the Board's professional judgment, a need for $178,400,000 in program funds for NAIMSD.

We concur that a need for that level of funding exists and would produce good science. The amount we urge you to appropriate would modestly launch NAIMSD on its important mission, and it is a level that should be supportable by every Member of Congress.

Thank you for the privilege and opportunity to present testimony on behalf of the Arthritis Foundation. I will be pleased to respond to any questions the committee may have.

Thank you, Mr. Chairman.

Mr. NATCHER. Thank you very much, Mr. Hollenbach. You have made an excellent statement. We appreciate your appearance before the committee.

[The statement of the Coalition of Organization concerned with Programs of the NIAMSD follows:]

COALITION OF ORGANIZATIONS
Concerned with the Programs of the
National Institute of Arthritis and
Musculoskeletal and Skin Diseases

Statement for the
Subcommittees on Labor, HHS, and Education
Committees on Appropriations
United States Senate
and
United States House of Representatives
with respect to the
FY 1987 Budget of the
National Institute of Arthritis and
Musculoskeletal and Skin Diseases
National Institutes of Health

Introduction

The Coalition of Organizations Concerned with the Programs of the National Institute of Arthritis and Musculoskeletal and Skin Diseases is pleased to have this opportunity to submit its joint statement on FY 1987 appropriations for the newest NIH research institute. The 30 organizations supporting this statement want to insure that the new NIH Institute is properly established as a fully functioning research institute at the earliest possible time.

The members of this Subcommittee are aware that NIAMS was established in law on November 20, 1985. Fiscal Year 1987 marks the first opportunity for Congress to address research needs of the programs encompassed by this new Institute as a separate budget line item.

The President has supported the creation of NIAMS, and the Congress has endorsed it through several nearly unanimous votes. We now urge you to appropriate funds for the new Institute at a level adequate to allow it to initiate the focussed, national research program contemplated by Congress at the time of its establishment.

Research Needs

Arthritis, rheumatic, and related musculoskeletal and connective tissue diseases, comprise over 100 distinct forms, affecting more than 38 million Americans, including as many as 250,000 children. The better known of these conditions are osteoarthritis, rheumatoid arthritis, gout, scleroderma, lupus erythematosus (SLE, or lupus), and ankylosing spondylitis, or spinal arthritis. Many millions more of our people have osteoporosis, osteogenesis imperfecta, Paget's disease of bone, pemphigus, ichthyosis, neurofibromatosis, tuberous sclerosis, alopecia areata, psoriasis, epidermolysis bullosa, Marfan's syndrome, vitiligo, melanoma, skin cancer, and other diseases of the bone and skin. In addition, there are many healthy Americans whose musculoskeletal systems are disabled by falls, fractures, motor vehicle accidents, and sports-related injuries.

All these serious diseases or conditions result in morbidity, mortality, and disability, which cost the American economy many billions of dollars each year in medical care, lost wages and productivity, lost taxes, increased disability and workers compensation payments, and increased social services costs. Research advances in the past decade have brought about improved treatment, control of disease, better diagnostic methods, and important new surgical procedures which strongly indicate that accelerated and targeted research efforts can sharply ameliorate, control, prevent, and cure a number of these diseases. This promise was a major reason for the creation of the new Institute. Now Congress and the President must give our Nation's scientists the means by which to fulfill the promise.

Biomedical research, and more specifically research to improve the lives of as many as 50 million Americans with arthritis, bone, and skin diseases, should be one of the highest of this Nation's priorities. The loss of momentum in biomedical research through reduced or level funding would mean a serious loss of research opportunity for many years to come and the real potential exists for the loss of an entire generation of investigators.

Funding Recommendations

Attached to this statement is a table showing funding necessary to maintain research efforts at current services levels, and the Coalition's recommendations for NIAMS appropriations for FY 1987.

The recommended support level for investigator-initiated research grants (RO-1) would fund 223 new grants in FY 1987, and a total of 612 new and continuation grants. At this level, the estimated award rate for new grants would be 34%, with a priority score payline of 170. The $100 million we urge is only 3% greater than the current services level.

Although the Coalition recommends funding at current service levels for training and contracts, we urge initial funding of Specialized Centers of Research (SCORs) to target multidisciplinary research approaches in three areas: osteoporosis, osteoarthritis, and rheumatoid arthritis, as both House and Senate Appropriations Committees recommended last year. We also request an increase of $2.4 million over current services in Centers funding to support six core centers in dermatology.

The "other research" category includes Clinical Investigator and Physician Scientist awards, both of which must have reasonable funding if our research community is to remain viable in future years. No new awards would be possible under the President's FY 1987 budget. Intramural research must be strengthened to complement extramural activity.

Institute Staffing

At current personnel levels, NIAMS cannot function as an independent Institute. Under the NIH organization plan, the Arthritis and Rheumatism Branch and Laboratory of Physical Chemistry in the NIADDK intramural program are transferred to NIAMS (35 positions), along with 14 extramural personnel. When the administrative separation from NIADDK takes place, an additional 8 slots are scheduled to be assigned to NIAMS. In order to be minimally effective as a working Institute, NIAMS requires another 36 personnel. Under the President's FY 1987 budget, $1 million additional is provided (but no positions) in the RMS (research management and support) activity. If positions are made available, this additional amount will permit the placement of 15 to 20 staff. Another $1.5 million is necessary to provide the minimum of 36 additional personnel.

Conclusion

The Coalition believes that the amounts it is recommending for FY 1987 are fiscally sound and minimally adequate to make NIAMS operational and effective as an NIH research institute. There is substantial scientific justification for the higher FY 1987 budget proposed by the National Arthritis Advisory Board. If the Congress determines these levels to be attainable this year, the Coalition would most certainly support them. At a minimum, however, we urge Congress to enact, and the President to approve, appropriations for FY 1987 at the level the Coalition recommends, to firmly establish NIAMS and to begin the level of research effort essential to finding the answers to the diseases addressed by the National Institute of Arthritis and Musculoskeletal and Skin Diseases.

LIST OF ORGANIZATIONS
ENDORSING STATEMENT ON FY 1987 APPROPRIATIONS

Coalition of Organizations Concerned with the Programs of the National Institute of Arthritis and Musculoskeletal and Skin Diseases

American Academy of Dermatology
American Academy of Orthopaedic Surgeons
American Academy of Physical Medicine and Rehabilitation
American Brittle Bone Society
American Congress of Rehabilitation Medicine
American Lupus Society
American Juvenile Arthritis Organization
American Rheumatism Association
American Society for Bone and Mineral Research
Arthritis Foundation
Arthritis Health Professions Association
Dystrophic Epidermolysis Bullosa Research Association
Federation of American Societies for Experimental Biology
Helen Hayes Hospital
Lupus Foundation of America
National Alopecia Areata Foundation
National Foundation for Ectodermal Dysplasias
National Ichthyosis Foundation
National Marfan's Foundation
National Osteoporosis Foundation
National Psoriasis Foundation, Inc.
Orthopedic Research Society
Osteogenesis Imperfecta Foundation, Inc.
Rehabilitation Institute of Chicago
Society for Investigative Dermatology
Terri Gotthelf Lupus Research Foundation
The Dermatology Foundation
The National Neurofibromatosis Foundation, Inc.
The National Tuberous Sclerosis Foundation
The Paget's Disease Foundation, Inc.
United Scleroderma Foundation

NIAMS

(Dollars in thousands)

	1985 Actual		1986 Appropriation plus Carryover		1987 President's Budget		Current Services		1987 Coalition Proposal
Grants	190/565	$77,554	199/582	$83,599	148/537	$75,011	199/588	$96,712	$100,000
Centers	14	10,064	14	10,231	14	9,317	14	11,909	14,309
Other	67	4,814	63	5,087	56	4,868	63	5,087	7,800
Training	233	6,130	268	6,130	257	5,867	268	6,130	6,130
Contracts	7	2,013	7	2,848	6	2,536	7	3,018	3,018
Intramural Res.		6,478		6,467		6,181		7,141	8,000
	49		49		48		49		4,743
RMS		1,755		2,136		2,953		3,243	7,650*
Totals		108,808		116,498		106,733		133,240	151,650

*New Item - Specialized Centers of Research (SCORs).

TUESDAY, APRIL 29, 1986.

NIAMSD

WITNESS

DR. HENRY J. MANKIN, MEMBER, NATIONAL ARTHRITIS ADVISORY BOARD

Mr. NATCHER. Our next witness is Dr. Henry J. Mankin. We will be glad to hear from you.

Dr. MANKIN. I am Henry J. Mankin, Chief of Orthopaedics at the Massachusetts General Hospital, and the Professor of Orthopaedics at the Harvard School of Medicine.

I am here on behalf of the National Arthritis Advisory Board, and on behalf of the more than 35,000,000 citizens of our country who are affected by arthritis of one sort or another, at a cost of about $18,600,000,000, and another 20,000,000 persons, mostly women over the age of 60, who have osteoporosis, a circumstance which leads to over 1,000,000 fractures, and estimated cost of $6,100,000,000.

The medical community and the NIH has recognized over the years the importance of these diseases, and a vast array of research efforts have been combined to develop new approaches to these problems.

We continue, as was indicated by some of the previous speakers, we continue to explore the possibility of an infective agent as a cause of rheumatoid arthritis and have made some material advances in the discoveries towards the genetic characteristics and immunologic changes occurring in that disease.

Osteoarthritis was the subject of a recent workshop by the NIH, and is not a wear and tear kind of change, but a cell-mediated disease, and which we have now had a very explosive increase in research, the basic control mechanisms of cartilage metabolism.

We are studying osteoporosis, efforts are directed towards the collagen fiber, and many new approaches which include looking at automated CT and MRI systems, as simple, safe and accurate ways of detecting this disease.

The total joint systems that my orthopaedic colleague talked about continue to be an important addition, new designs continue to be advanced, and we are in a third generation system with bony ingrowth devices, and all the systems are designed to work better, last longer.

I think I speak for all of the connected tissue disorders, we are also making advances in lupus, sports medicine, so on, all of which contribute to the welfare of the citizens of this country.

We at the National Arthritis Advisory Board are encouraged and proud of these efforts, and we anticipate even greater strides in the next decade, but feel that the problems which face us at this point will require increases in our current allotted budget to $178,400,000, and that is really a restoration to that figure.

We anticipate in terms of our research grant budget a reduction of 13 or more percent in our individual research grants, which will reduce the numbers of our old and new grants significantly, perhaps to the level where only 25 percent of those submitted will be funded.

We anticipate, unless we get relief in this area, a dip to a pay level of less than 150, which would be a disaster.

As far as the SCORs are concerned, we firmly believe that it would enhance our research efforts enormously, if we do develop some highly focused, multidisciplinary centers for research, and strongly urge such be established in fiscal year 1987.

The cost is about $7,500,000, and it would more than pay for itself in terms of projected research in the fields of rheumatoid arthritis, osteoarthritis and osteoporosis.

The great concern is the deficit and manpower and the current fiscal crunch has caused a serious erosion in our funding, and work in the development of research scientists. We need clinical investigator physicians scientists and career development awards, and we are also concerned about our institutional training grants, and hope that the budget can include these, or be expanded sufficiently to include these programs.

Finally, we are grateful to the Administration for the establishment of the NIH National Institute of Arthritis and Musculoskeletal and Skin Diseases, which we believe will aid us in focusing and organizing our programs in intra- and extramural research in all of these disorders.

We cannot begin, however, until we get the additional 36 FTEs and the $3,500,000 in administrative costs required to support these systems.

We hope that you will consider these suggestions favorably, and thank you for the privilege of presenting this.

[The statement of Dr. Mankin and attachments follow:]

STATEMENT OF HENRY J. MANKIN, M.D.

Member, National Arthritis Advisory Board

Before the House Subcommittee on Labor, Health and Human Services,
and Education and Related Agencies on Appropriations

(Appropriations for Arthritis-Related Research - NIH)

Tuesday, April 29, 1986

I am Henry J. Mankin, Edith M. Ashley Professor of Orthopedic Surgery, Harvard Medical School, and a member of the National Arthritis Advisory Board. I appreciate the opportunity to appear before you to present the recommendations of the National Arthritis Advisory Board.

Disorders of the joints and connective tissues afflict more than 35 million Americans, or 1 in 7 of all our people. More than 120 different disorders of the joints and connective tissues are categorized under the broad term "arthritis," a group of chronic diseases that is the Nation's leading crippler. Although the prevalence of arthritis is higher among older persons, an estimated 250,000 children have juvenile arthritis, which, in addition to causing pain and swelling of the joints, can retard growth and lead to early blindness, kidney disease, or death. Arthritis in children is, in fact, more prevalent than was paralytic poliomyelitis during the most severe epidemics of the past. Most forms of arthritis are chronic, and many patients unfortunately require lifelong medical care. The cost each year of hospital care, professional services and drugs for arthritis and the loss of productivity from arthritis is estimated at $18.6 billion.

In 1976, Congress enacted P.L. 94-562, which formally established the National Arthritis Advisory Board. The Board's purpose is to monitor the implementation of the Arthritis Plan, to recommend any changes in the Plan, and to propose to Congress and the Administration appropriate guidelines, policies, and procedures for Federal programs relating to arthritis. Our most recent annual report will be provided to the subcommittee today. My testimony is based upon the Board's findings and recommendations.

Advances in fundamental science are contributing to an improved knowledge of the disease processes and mechanisms of arthritis. A great deal of progress has been made in understanding these chronic, crippling disorders. Some of these diseases now can be partially controlled with medication and other types of therapy.

The research effort in arthritis encompasses three general areas: projects associated with immune disregulation, autoimmune diseases, rheumatoid factor, antigen-antibody reactions, and immune complex formation; research concerned with the structure and function of connective tissues such as collagen, basement membranes, synovial tissues, and articular cartilage damaged in the rheumatic diseases; and research projects in specific rheumatic diseases (rheumatoid arthritis, degenerative joint diseases, juvenile arthritis, systemic lupus erythematosus, gout, osteoporosis, and heritable disorders). A fourth related area of basic and clinical research involves the study of the musculoskeletal system in normal and diseased conditions.

Specific agents recently have been found that may initiate or trigger rheumatoid arthritis; these include infectious agents such as parvovirus and Epstein-Barr virus. Moreover, only certain persons who are susceptible to rheumatoid arthritis by their genetically determined immune responsiveness appear to develop the chronic and active inflammation of rheumatoid arthritis.

Research on newly developed animal models of arthritis is enhancing the scientific knowledge of these diseases.

Osteoarthritis, the most common form of arthritis, affects 16 million people in the United States. One of the most disabling and crippling diseases in older populations, it has been a difficult disease to study. Two recent research developments point to possible advances in our knowledge of osteoarthritis. In the first, biochemical observations indicate that cartilage cells produce the substances that both build and destroy the cartilage; this may lead to an understanding of why damaged cartilage is unable to repair itself and may help in discovering new ways to induce this repair. In the second development, several new experimental models of osteoarthritis offer the hope for greater knowledge of the cause of and new treatments for this disabling disorder.

Remarkable advances in reconstructive surgery for osteoarthritis and rheumatoid arthritis have been made during the past decade. Improvements have been achieved in total joint replacements for severely damaged hips, knees, shoulders, elbows, and wrists. These results have been achieved through the combined research efforts of bioengineers, rheumatologists, materials scientists, and orthopedic surgeons. Loosening of the joint implant after several years remains a problem. Nonetheless, the future holds promise for the development of implants that will provide normal joint function over an indefinite period.

Systemic lupus erythematosus (SLE) is a serious inflammatory connective tissue disorder that involves many organ systems. Research on SLE, a condition that primarily affects young women, continues to be active and productive.

More is being discovered about abnormal immunoregulation in SLE; for example, a newly identified defect in complement receptors on cells in lupus patients may be inherited. Dietary manipulation can alter SLE in experimental models in inbred mice; nonsaturated fatty acids may inhibit the disease-producing immune reactions in these SLE mice. Hormonal regulation also has been shown to be important in SLE and may explain the predominance of SLE in women.

The research potential is considerable for scleroderma, a serious connective tissue disease, and for the spondylitic (spinal arthritis) group of rheumatic diseases, such as ankylosing spondylitis (AS), Reiter's syndrome, psoriatic arthritis, and the gout-associated arthropathies. The Board believes that research in all arthritis-related diseases is at a critical point for major breakthroughs. New leads are emerging in many areas of investigation. Moreover, the availability of new biomedical research technologies such as monoclonal antibodies, recombinant DNA, molecular genetics, and computers is accelerating the pace of major scientific discoveries, yet needs to be exploited more fully.

The National Arthritis Advisory Board is encouraged by the accomplishments of research into the causes and mechanisms of arthritis and the development of new devices, surgical techniques, and drugs that are used to treat arthritis patients. These accomplishments result largely from the impetus generated by the Arthritis Plan that was developed by the National Commission on Arthritis and Related Musculoskeletal Diseases in 1976. The plan identified the major needs and opportunities in arthritis research and treatment and led to a modest increase in Federal appropriations for arthritis-related projects. However, the base of support for scientific investigation has been reduced in recent years because appropriations have not kept pace with the increased cost of biomedical research. Therefore, the research advances we have seen in the past decade are not likely to be duplicated in the future unless additional resources are provided. This reduction in the research base is a major concern to the Board, especially in light of the new and promising opportunities for progress in the prevention, early diagnosis, and treatment of arthritis.

Congress and the administration share the Board's concern about the impact of arthritis on the Nation. In 1985, the Secretary of Health and Human Services identified arthritis research as a departmental priority initiative and Congress authorized the establishment of a separate National Institute of Arthritis, and Musculoskeletal and Skin Diseases (NIAMS) in P.L. 99-158. These actions have laid the foundation for the growth of arthritis-related research programs. However, additional funds must be appropriated before the promise of 1985 can become a reality in 1986 and in the future.

To continue this important program, the appropriation for NIAMS must be increased in fiscal year 1987 and subsequent years. The Board has carefully considered the resources required for the above programs and recommends a total budget of $178.4 million for fiscal year 1987. This recommendation includes funds for the following:

Individual Research Grants: The percentage of approved grants for arthritis and related research projects that can be funded has declined steadily from about 45 percent a few years ago to approximately 25 percent in fiscal year 1985. In fiscal year 1986, this rate will drop even farther under current budget allocations. The Board's recommendations would restore the award rate to approximately 45 percent of approved grants.

Specialized Centers of Research (SCORs): One of the most important initiatives of the Board this year is to obtain Congressional support to establish SCORs in the field of arthritis and related diseases. This special research mechanism has been extremely effective in disease areas supported by the National Heart, Lung, and Blood Institute. The Board is convinced that the establishment of Specialized Centers of Research will provide an extraordinarily effective means of concentrating research personnel and resources on three initial areas of priority and opportunity: rheumatoid arthritis, osteoarthritis, and osteoporosis. SCORs are multidisciplinary, having both basic science and clinical research emphasis, ensuring that advances in basic science are rapidly translated into clinical application, and that clinical needs provide the direction for the basic science. The major recent advances in biomedical technology, as exemplified by the field of molecular biology, need to be rapidly applied to research dealing with arthritis-related diseases. SCOR programs provide an important addition to investigator-initiated research projects, and will spur rapid application of new biotechnological techniques to arthritis research.

In its report on the fiscal year 1986 budget for the Department of Health and Human Services, the Committee on Appropriations stated that SCORs "are useful mechanisms for accelerating research in areas where coordinated, multidisciplinary efforts are likely to produce rapid clinical applications of basic science advances." The Committee requested the National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases to prepare an assessment of the scientific feasibility and potential benefit of establishing SCORs in arthritis and related diseases. The resulting assessment clearly indicates that the SCOR mechanism would be a valuable adjunct to existing research programs in this area. The Board's recommendations include funds to establish 9 SCORs in 1987, three each in the areas of rheumatoid arthritis, osteoarthritis, and osteoporosis.

Arthritis Research Manpower: The Board also is concerned about the lack of adequate funds for the development of future research scientists. Three different types of individual career development awards are used to support arthritis and related research. The Clinical Investigator Award and the Physician Scientist Award are key to providing adequate opportunity for M.D.'s to acquire sufficient research training and experience in modern methods of biomedical technology to become qualified as independent investigators. The Research Career Development Award enables young established investigators, either M.D.'s or Ph.D.'s, to devote themselves entirely to research during a crucial state of career development. The budget for all these three awards has become so restricted that we anticipate a very severe decline in capacity to support current and future candidates. Funds for institutional training grants also have been severely restricted in recent years, leading to a steady decline in the number of young investigators selecting a research career. The Board's budget recommendations include additional funds to support these vital programs. The national investment in biomedical research manpower needs to be maintained and fully supported.

Establishment of the National Institute of Arthritis, Musculoskeletal, and Skin Diseases: The creation of this new institute, authorized by P.L. 99-158, will require additional personnel positions and associated funds for essential administrative and scientific functions. The need for these resources was well documented by the sponsors of the enabling legislation. Neither the funds nor the positions have been provided. The Board recommends that 36 additional positions be provided and $3.5 million be appropriated for this purpose.

The Board appreciates your support for arthritis research and the opportunity to appear before this Subcommittee. I will be pleased to respond to any questions you may have.

1985–86 Annual Report National Arthritis Advisory Board

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I. Introduction

Every year, 1 million Americans learn that they have arthritis, a disease that now afflicts nearly 37 million people in this country. Arthritis costs the Nation an estimated $18.6 billion annually in medical expenditures and associated economic losses. In addition to legitimate medical expenses, Americans spend more than $1 billion annually on quack devices and unproven remedies.

More than 7 million people are disabled by arthritis each year, and an estimated $1 billion is spent annually on disability aid and insurance. Some forms of adult and juvenile arthritis not only cause crippling of limbs but also result in kidney disease, blindness, and premature death. Arthritis is second only to heart disease as a cause of disability payments. For the average patient, arthritis can cost more than $150,000 in lost wages, medical care, and other expenses over a lifetime.

Any measure of economic impact, however, cannot adequately represent the personal and social burden of arthritis. Arthritis is estimated to affect more than 40 percent of the population over the age of 65. An estimated 250,000 children have arthritis or a related joint disease; of these, 100,000 will continue to have serious handicapping conditions into adulthood. Most forms of arthritis are chronic, and many patients require lifelong care.

Arthritis is a term that covers more than 120 kinds of diseases and disorders that occur in adults and children. Included are rheumatoid arthritis, osteoarthritis, all forms of juvenile arthritis, systemic lupus, and many inherited and acquired connective tissue disorders, such as scleroderma. The enormous toll of arthritis prompted Congress to pass the National Arthritis Act in 1975.

The Arthritis Act resulted in the establishment of the National Commission on Arthritis and Related Musculoskeletal Diseases. The Commission developed the Arthritis Plan, which outlined recommendations for research, education, and support services and for the establishment of the National Arthritis Advisory Board (NAAB) to monitor the plan and advise the Federal Government on arthritis-related activities. The Board consists of 18 appointed members who are drawn from the general public and associated medical, surgical, and health disciplines. Additional ex officio members represent Federal agencies with responsibility for related activities.

In reviewing arthritis research and the application of research knowledge to patient care, the Board serves a variety of constituencies: Government officials, scientists, health professionals, educators, patient advocates, and members of the general public.

In the past 9 years, the NAAB has recommended improved program approaches to the National Institute of Arthritis, Diabetes, and Digestive and Kidney Diseases (NIADDK) and other Federal, State, and private groups based on special studies, program site visits, review of the technical literature, public testimony, and expert advice.

The Board also prepares this annual report for public policymakers to update them on achievements in arthritis research and services and to advise them on current priorities and ongoing needs. The 1985-86 annual report has three objectives:

- To make recommendations for arthritis research funding priorities.
- To review the recent progress made in biomedical research and community education and services.
- To discuss mechanisms for expanding the application of research to patient care.

This year's National Arthritis Advisory Board annual report provides highlights of recent advances in arthritis research and treatment. It includes an analysis of current and recommended appropriations that are needed to achieve the objectives outlined above, which are discussed in detail in the following chapters. The needs and opportunities summarized in this report justify a strengthened and expanded Federal arthritis program.

II. Recommendations: Funding Priorities

The National Arthritis Advisory Board is encouraged by the accomplishments of research into the causes and mechanisms of arthritis and the development of new devices, surgical techniques, and drugs that are used to treat arthritis patients. The Board is also encouraged by the increased attention that the private and public sectors are paying to the treatment, education, and information needs of people who suffer from the chronic and debilitating group of diseases termed arthritis. Section III of this report, "Positive Steps Toward Arthritis Control," reviews some of these important advances.

These accomplishments result largely from the impetus generated by the Arthritis Plan that was developed by the National Commission on Arthritis and Related Musculoskeletal Diseases in 1976. The plan identified the major needs and opportunities in arthritis research and treatment and led to a modest increase in Federal appropriations for arthritis-related projects. However, the base of support for scientific investigation has been reduced in recent years because appropriations have not kept pace with the increased cost of biomedical research. Therefore, the research advances we have seen in the past decade are not likely to be duplicated in the future unless additional resources are provided. This reduction in the research base is a major concern to the Board, especially in light of the new and promising opportunities for progress in the prevention, treatment, and early diagnosis of arthritis.

Congress and the administration share the Board's concern about the impact of arthritis on the Nation. In 1985, the Secretary of Health and Human Services identified arthritis research as a departmental priority initiative. The President issued an executive order to establish a separate National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMSD), and Congress authorized the establishment of the new Institute (P.L. 99-158). These actions have laid the foundation for the growth of arthritis-related research programs. However, additional funds must be appropriated before the promise of 1985 can become a reality in 1986 and in the future.

P.L. 99-158 directs the National Institute of Arthritis and Musculoskeletal and Skin Diseases "to expand, intensify, and coordinate the activities of the Institute respecting arthritis and musculoskeletal diseases."

This expanded program provides for the following:

- Investigation into the epidemiology, etiology, and prevention of arthritis and musculoskeletal diseases.
- Research into techniques, drugs, and devices used in the diagnosis and treatment of these diseases.
- Research on technological devices that can replace damaged bones, muscles, and joints.

In addition, the Director of NIAMSD is required by the new legislation to:

- Establish a National Arthritis and Musculoskeletal and Skin Diseases Data System.
- Operate a National Arthritis and Musculoskeletal and Skin Diseases Information Clearinghouse.
- Provide for new and existing centers for arthritis and musculoskeletal diseases to conduct basic and clinical research; training programs for scientists, physicians, and other health professionals; and information and continuing education programs for health professionals.
- Support projects to develop and demonstrate methods for screening, detection, and referral for the treatment of arthritis and musculoskeletal diseases.
- Establish an interagency coordinating committee for arthritis and musculoskeletal diseases and an interagency coordinating committee for skin diseases.

To implement these important programs, the appropriation for NIAMSD must be increased in fiscal year 1987 and subsequent years. The Board has carefully considered the resources required for the above programs and has provided budget recommendations for fiscal years 1986 and 1987. These recommendations are summarized in table 1 and are described below.

Individual Research Grants: The percentage of approved grants for arthritis and related research projects that could be funded has declined steadily from about 45 percent a few years ago to approximately 25 percent in fiscal year 1985. In fiscal year 1986, this rate will drop even farther under current budget allocations. The Board's recommendations would restore the award rate to approximately 45 percent.

Multipurpose Arthritis Centers: As a result of limited appropriations, the budgets of these centers have been reduced administratively in recent years below the funding levels recommended by scientific study sections. In addition, five new centers with excellent priority scores could not be funded within recent appropriation levels. Therefore, the Board recommends the allocation of increased funds for these centers.

Specialized Centers of Research: The Board supports the initiation of multidisciplinary arthritis-related Specialized Centers of Research (SCOR's) that would capitalize on existing geographic aggregates of basic and clinical investigators who are capable of using advanced technology to pursue research on specific diseases. SCOR programs would encourage active collaboration among scientists and disciplines involved in arthritis research issues. The Board's recommendations include funds to establish nine SCOR's by 1987, three each in the areas of rheumatoid arthritis, osteoarthritis, and osteoporosis.

Research and Development Contracts: Contract funds are allocated to selected high-priority projects that require closer direction from Institute staff. The Board's recommended budget includes an additional $500,000 for clinical trials in the area of orthopedics and sports-related disorders in response to P.L. 99-158.

Equipment and Facilities for Extramural Research: P.L. 99-158 directs the Institute to "provide for the development, modernization, and operation of new and existing centers for arthritis and musculoskeletal diseases." Continued progress in research is highly dependent upon the upgrading of outdated facilities throughout the Nation. The Board includes modest funds for this purpose in its budget recommendations.

Intramural Research: Intramural research programs at NIH have continued to lead basic and clinical investigation into mechanisms of disease and the treatment of arthritis and musculoskeletal and skin disorders. This program has been severely hampered by recent reductions in personnel and research resources. The unique capabilities of the NIH Clinical Center must be encouraged and supported at a high level.

Research Career and National Research Service Awards: Previous Board reports have emphasized the increasingly critical problem of an inadequate supply of new investigators who are trained to solve research problems by using modern technology. The budget proposed by the Board includes a modest increase in funds for fellowships, training grants, and research career awards.

Table 1

Budget Recommendations for Fiscal Years 1986 and 1987:
National Institute of Arthritis and Musculoskeletal and Skin Diseases
(Thousands of Dollars)

	1986	1987
Individual Research Grants	$ 99,040	$112,459
Multipurpose Arthritis Centers	15,500	16,275
Specialized Centers of Research	5,000	7,650
Research and Development Contracts	4,160	4,868
Equipment and Facilities for Extramural Research	4,580	4,809
Intramural Research	9,128	9,584
Research Career Awards and Other Research	6,235	7,800
National Research Service Awards	6,250	6,530
Epidemiology and Data Research*	3,380	3,549
Education and Training, Conferences, Seminars, and Workshops	1,050	1,103
Arthritis Information Clearinghouse	229	240
National Institute of Arthritis and Musculoskeletal and Skin Diseases†	—	3,500
Total	$154,552	$178,367

*Not included in recommendation for research grants.

†A new National Institute of Arthritis and Musculoskeletal and Skin Diseases was authorized by P.L. 99-158. Creation of the Institute is dependent upon the appropriation of funds and personnel for essential administrative and scientific positions. This recommendation includes authorization for 36 new positions.

Epidemiology and Data Research: Previous Board reports have emphasized the need for new initiatives in epidemiology and related disciplines. P.L. 99-158 also directs the Institute to establish a "National Arthritis and Musculoskeletal and Skin Diseases Data System for the collection, storage, analysis, retrieval, and dissemination of data derived from patient populations." The Board has included additional funds for this purpose in its recommendations.

Education and Training, Conferences, Seminars, and Workshops: Institute-sponsored conferences and training programs continue to be a valuable tool for technology transfer, information dissemination, and professional and patient education about arthritis and musculoskeletal and skin diseases. These funds support technology transfer efforts such as the NIH Consensus Development Conferences on Osteoporosis and on Total Hip Joint Replacement. They also support workshops on patient education and other research-related conferences such as those discussed in section V of this report, "The Future in Biomedical Research."

Arthritis Information Clearinghouse: The effective dissemination of information about arthritis and musculoskeletal and skin diseases to health professionals, patients, and the public is an essential component of the Arthritis Plan. P.L. 99-158 endorses this activity, and the Board has included additional funds for the clearinghouse in the recommended budget.

National Institute of Arthritis and Musculoskeletal and Skin Diseases: The creation of NIAMSD will require additional personnel and funds for essential administrative and scientific positions. Sponsors of the enabling legislation have documented the need for these additional resources. The positions and funds have not yet been approved. Therefore, the Board recommends that Congress and the administration provide 36 additional positions and $3.5 million to establish the new National Institute of Arthritis and Musculoskeletal and Skin Diseases authorized by P.L. 99-158.

Although NIAMSD is the lead agency for the Arthritis Plan, significant activities are supported by other NIH Institutes, other agencies within DHHS, the Veterans Administration, and the National Institute for Handicapped Research of the Department of Education. Table 2 shows expenditures for arthritis and related diseases by other NIH Institutes. The Board recommends that the administration and Congress provide additional resources to these agencies for arthritis-related activities.

The Board's recommendations represent the minimum resources necessary to continue the overall arthritis program, to establish the new Institute authorized by P.L. 99-158, and to initiate the programs authorized in that legislation. The implementation of these recommendations will move the Nation closer to the goal of reducing the medical, social, and economic impact of arthritis.

Table 2

Expenditures of Other NIH Institutes for Arthritis and Related Diseases
(Thousands of Dollars)

	1983 Actual	1984 Actual	1985 Actual
National Institute of Allergy and Infectious Diseases	$ 8,176	$11,536	$12,845
National Institute of Dental Research	3,087	3,465	3,700
National Institute on Aging	2,058	2,041	1,649
National Heart, Lung, and Blood Institute	1,634	1,728	1,744
National Institute of Child Health and Human Development	1,299	1,552	1,808
National Institute of Neurological and Communicative Disorders and Stroke	1,142	3,206	3,536
National Institute of General Medical Sciences	1,026	1,003	1,230
National Cancer Institute	879	997	811
National Institute of Environmental Health Sciences	72	90	0
Division of Research Resources	3,220	3,551	4,080
Total	$22,593	$29,169	$31,403

III. Positive Steps Toward Arthritis Control

Advances in fundamental science are contributing to the knowledge of the disease processes and mechanisms of arthritis, including the role of infectious agents and immunologic and endocrinologic factors. A great deal of progress has been made over the past three decades in understanding these chronic, crippling disorders. Some of these diseases now can be partially controlled with medication and other types of therapy.

The research effort in arthritis encompasses three general areas: projects associated with immune disturbances, autoimmune diseases, rheumatoid factor, antigen-antibody reactions, and immune complex formation; research concerned with the structure and function of connective tissues such as collagen, basement membranes, synovial tissues, and articular cartilage damaged in the rheumatic diseases; and research projects in several specific rheumatic diseases (rheumatoid arthritis, degenerative joint diseases, juvenile arthritis, systemic lupus erythematosus, gout, osteoporosis, and heritable disorders).

A fourth area of basic and clinical research involves the musculoskeletal system in normal and diseased conditions and includes investigations of the properties, growth, and metabolism of normal bone; bone and joint diseases, including metabolic bone diseases and inherited connective tissue diseases; musculoskeletal injury and repair; disorders of skeletal support structures such as tendons and ligaments; and specialized studies in areas such as low back pain and locomotion. The increasingly important areas of exercise pathophysiology and sports medicine are also being studied. Research in joint replacement, bone and cartilage transplantation, and fracture healing has helped to restore mobility and relieve pain for many Americans with orthopedic problems.

This section discusses some of the promising results of nationwide biomedical research activities, biomedical studies at the selected Multipurpose Arthritis Centers (MAC's), and community demonstration programs at the MAC's that test approaches to patient and professional education and service delivery.

Research Highlights

Significant advances in biomedical research, supported by NIADDK and other Institutes at NIH, have improved our understanding of the causative mechanisms of some of the rheumatic diseases. For example, specific agents recently have been found that may initiate or trigger rheumatoid arthritis; these include parvovirus and Epstein-Barr virus. Moreover, only certain persons who are susceptible to rheumatoid arthritis by their genetically determined immune responsiveness develop the chronic and active inflammation of rheumatoid arthritis. Research on newly developed animal models of arthritis is enhancing the scientific knowledge of these diseases. Important information also is being obtained from a human type of arthritis, Lyme arthritis, that was discovered just 10 years ago. It was found recently that Lyme arthritis is caused by a tick-borne spirochete, a bacteria-like organism that can be treated effectively with antibiotics.

Osteoarthritis, the most common form of arthritis, affects 16 million people in the United States. One of the most disabling and crippling diseases in older populations, it has been a difficult disease to study. Two recent research developments point to possible advances in our knowledge of osteoarthritis. In the first, biochemical observations indicate that cartilage cells produce the substances that both build and destroy the cartilage; this may lead to an understanding of why damaged cartilage is unable to repair itself and may help in discovering new ways to induce this repair. In the second development, several new experimental models of osteoarthritis offer the hope for greater knowledge of the cause of and new treatments for this disabling disorder.

Remarkable advances in reconstructive surgery for osteoarthritis and rheumatoid arthritis have been made during the past decade. Improvements have been achieved in total joint replacements for severely damaged hips, knees, shoulders, elbows, and wrists. These results have been achieved through the combined research efforts of bioengineers, rheumatologists, materials scientists, and orthopedic surgeons. Loosening of the joint implant after several years remains a problem. Nonetheless, the future holds a promise for the development of implants that will provide normal joint function over an indefinite period.

Systemic lupus erythematosus (SLE) is a serious inflammatory connective tissue disorder that involves many organ systems. SLE is characterized by various immunologic abnormalities, including a large number of autoantibodies (i.e., antibodies that react against a person's normal endogenous cell nuclear constituents). Research on SLE, a condition that primarily affects young women, continues to be active and productive. More is being discovered about abnormal immunoregulation in SLE; a newly identified defect in complement receptors on cells in lupus patients may be inherited. Dietary manipulation can alter SLE in experimental models in inbred mice; nonsaturated fatty acids may inhibit the disease-producing immune reactions in these SLE mice. Hormonal regulation also has been shown to be important in SLE and may explain the predominance of SLE in women.

Scleroderma is another serious connective tissue disorder, predominantly affecting middle-aged women and men but occasionally affecting children. This relatively rare condition is characterized by diffuse fibrosis and vascular abnormalities in the skin, joints, tendons, muscles, and certain internal organs, especially the gastrointestinal tract (esophagus), lung, heart, and kidney. During the course of scleroderma, the synthesis of connective tissue components (collagen and glycosaminoglycans) by cells (fibroblasts) increases, and various humoral and cell-mediated immunologic reactions occur in the vascular system and parenchyma of these organs. It is now clear that very small blood vessels are important in the pathogenesis of scleroderma at a primary level. Studies are needed to link the vascular and immunologic abnormalities with the fibrotic responses in scleroderma. New animal models such as the tight-skin mouse have been developed for such studies. Research also is needed in the biology of cells that line the walls of small blood vessels and the roles of histamines and kinins in these cells.

The research potential is considerable for the spondylitic (spinal arthritis) group of rheumatic diseases, such as ankylosing spondylitis (AS), Reiter's syndrome, psoriatic arthritis, and the gout-associated arthropathies. Ankylosing spondylitis, the prototype of these diseases, is a chronic systemic inflammation that primarily affects the spinal column. Joint involvement in ankylosing spondylitis appears to originate where cartilage and ligaments are attached to bone and the synovium.

Sacroiliac joint involvement is the distinctive feature of the spondylitic diseases, which mainly affect young men and often begin in childhood. An infectious etiology by several different micro-organisms has been reported to be associated with the development of these diseases. The role of the special tissue antigen HLA-B27 in spondylitis needs to be investigated further, as do the reasons that the diseases are predominant among males.

The Board believes that research in the rheumatic diseases is at a critical point for major breakthroughs. New leads are emerging in many areas of investigation. Moreover, the availability of new biomedical research technologies such as monoclonal antibodies, recombinant DNA, molecular genetics, and computers is accelerating the pace of major scientific discoveries.

Biomedical Research Efforts in Multipurpose Arthritis Centers

NIADDK supports 13 Multipurpose Arthritis Centers, which carry out multidisciplinary studies in basic and clinical research, as well as demonstration programs in the educational and health services aspects of arthritis control (discussed in the next subsection). MAC support for biomedical research is designed to encourage young investigators and those new to the field of arthritis to explore interdisciplinary and highly innovative scientific approaches that may later form the basis of applications for traditional research grant awards from NIH or other agencies. Biomedical research is also supported by core units, or common-use facilities, that are designed to increase the effectiveness and efficiency of each center's activities. Core units for tissue culture, connective tissue metabolism, immunology, histocompatibility testing, and hybridoma work are examples.

Biomedical research activities that are conducted at the MAC's include the following:

- Studying the significance of monocytosis in the development of autoimmune disease in BXSB mice.

- Investigating the phenomenon of fibrosis—excess tissue leading to scar formation in organs and joints—in arthritis.

- Studies of arthritic synovial (joint lining) tissue—for example, evaluating the possibility that dendritic cells present in synovial tissue interact with immune T and B cells to influence the pathophysiology of rheumatoid arthritis.

- Employing gait analysis to evaluate the results of total knee replacements to devise a functional performance index that is related to the disability for each lower extremity joint.

- Evaluating new imaging techniques to assess early cartilage damage of osteoarthritis.
- Studying the role that viruses may play in murine polymyositis to determine how the immune system affects the disease process.
- Determining if cellular reactivity to cartilage components is correlated with clinical disease in children with juvenile rheumatoid arthritis.
- Investigating synovial-cartilage relationships in experimental osteoarthritis and immune synovitis with respect to prostaglandin metabolism to advance the understanding of relationships among hormones, certain drugs, and inflammation on prostaglandin content and synthesis by synovium and chondrocytes.
- Analyzing the risk factors for osteoarthritis. Radiographs of hands and wrists taken approximately 20 years ago are being reread, and data concerning weight, socioeconomic status, occupational activity, joint symptoms, and biochemical parameters are being analyzed. A computerized data set is being assembled to include interview results, clinical examinations, x rays, and other tests.
- Investigating the relationship of oral contraceptives to the development of rheumatoid arthritis to determine whether the use of oral contraceptives protects women from this disease, as has been suggested. If the protective effect of oral contraceptives is confirmed, it will contribute to our understanding of the pathogenesis of rheumatoid arthritis and will yield information on the relationship between sex steroids and autoimmune disease.

MAC Innovations in Education and Service Delivery

Arthritis is a chronic condition whose alleviation requires exercise, lifestyle changes, and psychological coping skills in addition to medical treatment. Improving the outlook for patients thus involves making strides in educating patients and professionals and in structuring health services to facilitate comprehensive care. The MAC's conduct studies and demonstration programs that promote the application of new knowledge and the results of multidisciplinary clinical research to patient care.

The following highlights illustrate the scope of the MAC's work and their contributions to improving the treatment of arthritis:

- A program at the University of Alabama Arthritis Center in Birmingham has personalized inpatient education about arthritis. A tailored course of instruction replicable in other sites was developed, and patient outcomes were assessed, including pain, anxiety, and functional status. The results revealed that personalized instruction produced significantly more learning in patients than did nonpersonalized education.
- A patient education project at the University of North Carolina Arthritis Center in Chapel Hill is developing ways for health professionals to improve patient compliance with treatment regimens. Each patient is interviewed to identify physical, psychological, social, and environmental inhibitors and facilitators of compliant behavior to help plan effective interventions to increase compliance.
- In a study at the Stanford University Arthritis Center in Palo Alto, California, more than 350 patients have been followed for 7 years with assessments of treatment, disability, symptom levels, patterns of care, and economic impact. Results show that self-reported data from patients are accurate and can be used with confidence by physicians.
- Investigators at the Arthritis Center at Brigham and Women's Hospital in Boston, Massachusetts, are evaluating the effectiveness of lay psychological support provided to children with juvenile rheumatoid arthritis by parents who have been trained in preventing and reducing psychosocial maladjustment in these children and their families.
- Indiana University's Arthritis Center in Indianapolis compared routine arthritis health professional team management in rheumatoid arthritis with occasional referral care by team members. At the conclusion of the study, patients who received standard medical management of their disease demonstrated either no change in their condition or greater disease activity than they had at the onset of the program. Patients who were evaluated regularly by each member of a treatment team (i.e., physical and occupational therapists, social workers, and nurse educators) in addition to their physician had less disease activity, some increases in range of motion, and a tendency to have more positive attitudes about themselves and their families.

IV. Continued Needs: Expanding the Applications of Research to Patient Care

Advances in research make it clear that significant and exciting progress is being made in understanding arthritis and in improving its treatment and care. Through mechanisms such as the Multipurpose Arthritis Centers, we are also taking positive steps to translate research advances into demonstrably improved outcomes for arthritis patients. This process is neither simple nor automatic. The multidisciplinary nature of the arthritis community and the factors inherent in the health care system can indirectly affect our ability to give patients the benefits of research progress. The Board has identified five areas where research applications can enhance patient outcomes.

1. Expanding and Standardizing the Collection and Analysis of Epidemiologic Data

Epidemiologic studies of arthritis and musculoskeletal diseases are essential to assess the community's economic and social burden, determine the natural history of the diseases, investigate disease etiologies, and identify risk factors in adults and children.

The National Data Workgroup, which is developing a broader and more reliable data base on the rheumatic diseases, has reported that no descriptive national data sets exist for most rheumatic diseases. For some rheumatic diseases, one or multiple data sources are available but must be used with great care. No single source provides the best national estimates of the rheumatic diseases.

Osteoarthritis, the most frequently reported rheumatic disease, exemplifies the problems with existing data. Osteoarthritis has no uniformly accepted set of diagnostic criteria, and many people with radiographic evidence of osteoarthritis are asymptomatic. Assuming that diagnosis requires x rays, it is unethical and prohibitively expensive to x ray all joints in all persons in a study with adequate sample size. Therefore, the prevalence of radiologic changes that are indicative of osteoarthritis generally must be given for specific joints. Finally, the magnitude of prevalence rates for osteoarthritis varies considerably, depending upon whether only moderate and severe radiologic changes are counted or whether mild changes are also included.

To address these needs, NIADDK, the Arthritis Foundation, and the Centers for Disease Control have collaborated to develop the National Data Workgroup. The workgroup has reviewed disability data and updated current information on the prevalence, incidence, and cost of arthritis. The workgroup soon will publish two journal articles that contain the best available prevalence figures for the major rheumatic diseases and the financial burden incurred by them.

The workgroup has reviewed the data-gathering system of the National Center for Health Statistics (NCHS) and the content of the specific rheumatic disease items included within the surveys conducted by NCHS. The workgroup functions as an advisory body and makes recommendations for future NCHS surveys on arthritis and related musculoskeletal diseases.

Another valuable mechanism for enhancing epidemiologic data resources is the American Rheumatism Association Medical Information System (ARAMIS) that is administered at Stanford University. This multi-institutional data bank gathers prospective information and maintains long-term contact with patients to identify risk factors for arthritis and improve the diagnostic classifications and criteria for rheumatic diseases. A variety of evaluation instruments for epidemiologic studies have been developed within ARAMIS.

NCHS is cooperating with a variety of agencies to develop the third National Health and Nutrition Examination Survey (NHANES-III) instrument to be administered to a national population sample. Questions about arthritis have been included in previous NHANES studies, providing valuable data on morbidity and mortality, on the natural history of rheumatic conditions, and for longitudinal investigation. The Board supports the inclusion of arthritis-related questions in NHANES-III and recommends that NIAMSD allocate the resources necessary to participate.

2. Improving Arthritis-Related Knowledge and Skills Among Health Care Professionals

The Board has identified three skill areas whose enhancement would improve patient care. The first is providing referral information and criteria to primary care physicians. Timely referral to specialized care can make the difference between a poor prognosis and a positive outcome based on state-of-the-art therapy.

Second, nurses, physical therapists, occupational therapists, social workers, and other health professionals need more specific training in rheumatology. With up-to-date skills, these providers can have a positive effect on the patient's situation. Similarly, more specific training in rehabilitation rheumatology for primary care physicians would upgrade the support that patients receive from the health care team. This subject has not received adequate attention in educational curriculums.

Third, the ability of health professionals to communicate information to patients about their conditions, treatments, and self-care is an essential skill. Many medical schools and other professional curriculums do not teach practical skills in patient education. Physicians and health professionals need training in behavioral science approaches to patient care and education. Where such programs do exist, they should be accelerated; where they do not exist, they should be instituted.

One resource that aids both arthritis patient management and patient education skills is the Arthritis Information Clearinghouse. The major function of the clearinghouse is to collect, screen, store, and distribute information about educational materials and programs in the rheumatic diseases to health professionals who serve arthritis patients.

The clearinghouse prepares and distributes bibliographies, catalogs, and other materials; helps users locate and select educational materials; refers inquirers to appropriate sources for other information; and provides sample catalogs, bibliographies, and biblioprofiles (brief state-of-the-art reports) for professional meetings. It also offers reference services to educators, clinicians, and researchers in the field of rheumatic diseases. Its data base consists of about 5,000 citations and abstracts of print and audiovisual materials, journal articles, pamphlets, reports, textbooks, and other items. The Board believes that the clearinghouse fulfills a crucial service for health professionals and the patients whom they serve.

3. Improving Patient Education for Persons With Arthritis

Greater knowledge of arthritis is important not only for health care professionals but for patients. Several recent studies offer guidelines for the development of patient education materials. In one study, both health care professionals and patients ranked psychosocial issues first among patient education topics for rheumatoid arthritis; however, health care practitioners involved in diagnosis and treatment often do not address these critical issues. Teaching coping skills to arthritis patients offers one valuable tool in alleviating their psychosocial problems.

Recent studies also show that presurgical patient education reduces postoperative anxiety and pain and expedites recovery, as measured by reduced days to discharge and decreased use of pain medication. The practical application of these findings should include patient education in the preparation for orthopedic surgery.

Juvenile arthritis presents special problems because the family is intimately involved with the treatment and because developmental aspects of the parent-child relationship complicate the situation. Improved patient education techniques for both children and their families are needed.

Finally, members of different cultures have widely varying beliefs and behaviors toward disease that can affect their interactions with the health care system. More research is required about the communications needs of arthritis patients from minority populations. Patient education materials and individual counseling efforts should be targeted to minority needs and characteristics.

4. Improving Access to Arthritis Services by Expanding Third-Party Reimbursement Coverage

Despite the advances made in arthritis treatment, it is clear that certain ethnic and socioeconomic population groups have not benefited as much as others from research progress. Health insurance may be more difficult to obtain for members of these groups, which may interfere with their access to arthritis services.

To promote widespread and equal access to the professional and therapeutic services that are required for the optimum care of a chronic disease such as arthritis, financing and reimbursement issues need to be explored for arthritis, as they have been for other chronic diseases, such as diabetes and cancer. In addressing this problem, the following issues need to be considered:

- Availability of health insurance for people with arthritis, including special problems for members of minority groups, low-income populations, and the elderly.
- Coverage for preventive services, including patient education, that could reduce the need for more costly treatment.
- Coverage for therapeutic supplies and devices that have a significant impact on the patient's employability and quality of life.
- Reported problems that are related to prospective payment (diagnostic-related groups) and capitation systems.
- Coverage for the services of nonphysician health professionals, such as physical and occupational therapists and podiatrists.

5. Enhancing the Mechanisms That Facilitate Information Sharing Within the Health Care Community

Activities such as those of the Arthritis Information Clearinghouse, ARAMIS, the Arthritis Foundation, and the American Rheumatism Association provide important mechanisms for disseminating research results and educational information nationwide. Many state and local groups have also developed effective networks for patient and professional education. These efforts have facilitated communication about state-of-the-art treatment within the arthritis community. Within the larger health care community, however, gaps still exist between research-based clinical knowledge and the practical application of new diagnostic, treatment, and prevention measures.

The Board is focusing attention on initiatives to address this issue by identifying and ranking opportunities to expand the applications of new research to the primary care physician and other health professionals who are likely to see arthritis patients. The Board will identify rheumatic diseases in which advances in clinical knowledge and management techniques have not been effectively translated into improved patient outcomes at the community level. Based on information from experts within the arthritis community and from other health care professionals, the Board can determine priorities among the areas that need better application to patient care and can develop strategies to accomplish these objectives. The result will be a consensus plan for promoting specific professional and patient practices that can improve the health status of arthritis patients.

V. The Future in Biomedical Research

In addition to promoting initiatives that address applying current research results, the National Arthritis Advisory Board is also concerned with the directions that future arthritis research will take. Careful assessment of the current state of the art is a critical first step in planning future research. The recommendations of experts for the most necessary and promising avenues of new investigation are equally essential.

To accomplish both of these steps, the Board is working with other organizations in the development and support of conferences on arthritis topics of interest. These meetings are reviewing completed research and looking at the next steps that the research community should pursue.

Osteoarthritis Conference

A workshop on osteoarthritis, cosponsored by NIADDK, NAAB, the National Institute on Aging, and several voluntary and professional organizations and pharmaceutical firms, was held in July 1985. The conference addressed specific questions about osteoarthritis, such as:

- What are the epidemiologic factors for osteoarthritis?
- What are the roles of acute or chronic trauma in the pathogenesis of osteoarthritis?
- How do the anatomic, physiologic, chemical, and mechanical alterations in cartilage matrix interrelate in the pathogenesis of osteoarthritis?
- What roles do extra cartilagenous structures play in osteoarthritis?
- Does articular cartilage repair itself in trauma and osteoarthritis?
- What are the roles of aging factors in different types of osteoarthritis?
- Under what circumstances does inflammation develop in osteoarthritis?

The outcome of the meeting was a conference-generated report identifying more than 84 areas of study, including:

- The development of new taxonomic systems of osteoarthritis designed specifically for epidemiologic studies.
- The development of suitable animal models and appropriate systems for the study of synovial mediators.
- Studies to elucidate further the alterations observed in calcified cartilage and subchondral bone and the role that these alterations play in the pathogenesis of osteoarthritis.
- Studies of the composition and three-dimensional structure of proteoglycans and the nature of cross-linking of the fibrillar network in the presence of an adhesive protein.
- Prospective studies of the effects of nonsteroid autoinflammatory drugs in osteoarthritis.
- The metabolism of articular cartilage proteoglycans in normal and aged tissue.

The report on this conference will be published.

Research Conference on Bone Destruction in Paget's Disease

NIADDK held a workshop in September 1985 to review current knowledge on the role of the osteoclast in bone diseases such as Paget's disease. Paget's disease is a common disorder of abnormal bone remodeling that causes misshapen and painful bone structures. This workshop was the first to focus on this important topic, which has been the subject of much recent research. Participants discussed several possible etiologies for this condition and generated recommendations for potential treatment of the disease. The results of the conference are being summarized for journal publication.

Conference on Rheumatic Diseases of Childhood

The Board and several other arthritis professional organizations cosponsored a conference in March 1986 on the rheumatic diseases of childhood, bringing together basic scientists, health services investigators, educational specialists, and chronic disease experts from adult and pediatric disciplines. This 4-day program was designed to assess and promote new directions in biomedical research related to growth and development, chronic arthritis-related eye disease in children, and the autoimmunity of nuclear proteins. The development of health status measures for pediatric rheumatic diseases was also a focus of the conference.

Arthritis Rehabilitation Research Conference

The Arthritis Interagency Coordinating Committee and the Arthritis Foundation are sponsoring a conference on rheumatology, rehabilitation, and research in cooperation with the National Institute for Handicapped Research to be held in July 1986 at the University of Virginia. The Board is helping to sponsor this conference, which will bring together leading investigators in rehabilitation rheumatology to review the state of the art of research in this field.

Molecular Biology: Its Potential for Advancing Rheumatology Research

During the past 5 years, advances in biotechnology have revolutionized biomedical research. Major advances in many fields of medical research have resulted from the development of monoclonal hybridoma technology, high resolution molecular separation techniques, and in particular, the technology of molecular biology. The Board is planning a conference to determine what impact such advances have had on research related to the rheumatic diseases and what potential breakthroughs might be possible by applying such new techniques to research in rheumatic diseases. The conference will be held on October 19-21, 1986, at the Clinical Center of the National Institutes of Health.

The conference program is designed to bring advances in fundamental molecular research to the attention of young investigators, research associates, fellows in training, and physician scientists. It will facilitate the interaction of experts in gene cloning and molecular and cell biology who have done formative research in areas related to rheumatic diseases. Leading investigators, already using such techniques for the study of rheumatic diseases, will describe their current research and potential applications. In addition, molecular biologists not currently involved in the study of rheumatic diseases will discuss potential applications of such techniques to the rheumatic diseases.

VI. Conclusion

The Arthritis Plan marked an important milestone in the Nation's effort to combat the problems of arthritis. Ten years have now passed since the National Commission on Arthritis and Related Musculoskeletal Diseases issued the plan. These 10 years have witnessed important advances in arthritis research and treatment. Many of these advances are attributable directly to the impetus provided by the Arthritis Plan and have resulted in improved care for people with arthritis.

Over the past 9 years, the Board has assessed the progress of the Arthritis Plan and has reviewed the accomplishments and needs of the Government and the private sector in arthritis. These assessments have formed the basis for recommendations that the Board believes will continue to improve the condition of people who suffer from arthritis. At the same time, the Board has served as an important link between the various members of the arthritis community—patients and their families, health professionals, professional societies, voluntary organizations, academic and research institutions, and Government agencies.

This year marks a new milestone in arthritis research and treatment— the creation of the National Institute of Arthritis and Musculoskeletal and Skin Diseases. This new Institute now joins the 11 other Institutes of NIH as a separate entity, providing a focus for arthritis-related research, training, and education. The Board looks forward to continuing its representation and record of service within the arthritis community in the coming years.

Mr. Natcher. Doctor, you have made an excellent statement. We appreciate your appearance before the committee.

Mr. Conte. Mr. Chairman, I want to join you in welcoming Dr. Mankin. He is from the great institution, the Massachusetts General Hospital in Boston.

By the way, I know that it is not in your area, but something I have been following now for a couple of years: do you know if the hospital is moving on the idea of naming the Huntington Disease Center after my dear, departed friends, Woody and Marjorie Guthrie?

Dr. Mankin. I don't know the answer.

Mr. Conte. Thank you, Doctor, I'd appreciate it if you'd drop me a note on that.

Mr. Natcher. Thank you very much.

Tuesday, April 29, 1986.

GAUCHER'S DISEASE

WITNESSES

JUDITH L. SHULMAN, NATIONAL GAUCHER FOUNDATION

JILL TALISMAN, EXECUTIVE DIRECTOR

Mr. Natcher. Our next witness is Ms. Judith L. Shulman. Come around, Ms. Shulman.

Ms. Shulman. Mr. Chairman, and members of the subcommittee, I would like to thank you for inviting me to testify before you today and for your ongoing concern and interest in Gaucher's disease.

We will be submitting additional material for the record. I will introduce Ms. Jill Talisman, Executive Director of the National Gaucher Foundation, who is accompanying me.

My name is Judith Shulman. I am a woman, a wife, a mother and a victim of Gaucher's disease.

Gaucher's disease is the result of a genetic disorder in which the body fails to produce sufficient amounts of an enzyme, glucocerebrosidase, that, in normal amounts, breaks down fatty material that collects in the spleen, liver, bone marrow and, in some cases, the lung, heart and brain.

In some people, the effects of Gaucher's disease include periodic severe bleeding episodes, anemia, painful bone inflammation, infection, pathologic fractures from eroded bones and enlarged spleens and livers.

Depending on the specific type of genetic abnormality the disease may also cause rapid nervous system deterioration, causing retardation, seizures and abnormal eye and body movements, with expectations of a foreshortened life span.

It is estimated that over 20,000 people in the United States alone have Gaucher's, and many more are carriers whose children may be unlucky enough to have the disease.

I discovered I had Gaucher's disease during my pregnancy with my second child when I became so anemic that my baby was threatened. A bone marrow biopsy revealed that I had Gaucher's.

Fortunately, my doctor was aware of Dr. Barringèr's research program at NIH, and put us in touch with him the same day. NIH personnel saw me the next day and were extremely supportive throughout the rest of my pregnancy, including four transfusions.

I was one of the "lucky ones." Often, Gaucher's disease patients waste years before discovering the expertise and caring assistance at NIH. You cannot imagine the psychological and emotional importance to a victim of this difficult and painful disease to have a place like NIH available for research, care and counsel.

I have a reasonably mild case of Gaucher's disease, but during the last four years, I have had constant below normal blood counts and my spleen has enlarged beyond its normal size.

Most significantly, as Gaucher's cells increasingly invade my bone marrow I have suffered repeated, severe and debilitating episodes of bone pain. I now must use a cane or a wheelchair for any extended outing.

My eight and a half-year-old Katharine, when asked what it is like to have a mother with Gaucher's disease, said, "I have got to do a lot more work around the house. And when we went to Disney World, I had to push my younger sister in a stroller everywhere, since my Dad was busy pushing my Mom in her wheelchair."

I asked my daughter what her feelings were, and said her strongest emotion was "fear." She is afraid when I go to the hospital, when I go for doctor's visits and when she sees me in pain, which is unfortunately often.

Both my girls live with a mother who often can't pick them up or run around with them, and who frequently must simply rest in bed in sharp pain. Last fall, my younger daughter Victoria came to ask me to play.

Seeing me in pain she said, "Never mind, I will go be quiet and watch Sesame Street, and let you rest, Mommy." She was only 3 at the time.

My husband, a partner in a major Washington law firm, has let it be known that if I call I can get through immediately, and if I need him at home, he leaves immediately.

This has occurred in the midst of conference calls, meetings and just plain busy days. Because my anemia and bone problems frequently leave me to weary to cope, my husband must frequently follow a long day at the office by taking charge of our children and putting both to bed. And then he must take care of me.

Thus, quite beyond its physical and emotional toll on me, Gaucher's disease has a very wide range and painful impact on my family as well. Whenever you consider the number of victims of Gaucher's disease during your deliberations, please remember that family of Gaucher's patients are victims, too.

I live a life of exhaustion and frequent pain. I live with the knowledge that my disease is progressing and that there is no cure in sight, yet. I live with the knowledge of how much turmoil and pain this disease has caused my husband, my children, my parents, my family and my friends.

And yet, I have what is called a relatively mild case of Gaucher's. How much more tragic are the children, and adults, with more severe forms of the disease.

Amidst my pain and frustration, my biggest hope is that current research on Gaucher's disease, especially at NIH, will succeed in finding ways to alleviate the pain associated with the disease, and someday finding a cure.

Please remember that it was only in 1984 that NIH broke the genetic code for the missing enzyme that causes Gaucher's disease, a breakthrough that hopefully will soon allow scientists to be producing substantial quantities of the previously scarce enzyme.

This breakthrough, and the experiments that now can follow, makes Gaucher's disease research a prototype for treatment of a host of lipid storage and related diseases.

It has been estimated that the lessons learned in Gaucher's disease will unlock mysteries of another 300 other genetic diseases. Thus, your funding of continued research on Gaucher's disease has a multiplier effect on all kinds of other research on genetic diseases.

Research on Gaucher's disease is at a critical point, when recent breakthroughs can lead to significant advanced in treating a hitherto untreatable disease. Please continue your active support for this research now.

Thank you for your attention.

Mr. NATCHER. We want to thank you. You have made an excellent statement. We appreciate your appearance before the committee.

Ms. SHULMAN. Thank you.

[The attachments to the Gaucher Foundation's statement follow:]

GAUCHER'S DISEASE

In 1882, Phillippe C. E. Gaucher first described the rare, hereditary enzyme deficiency disorder that now carries his name: Gaucher's Disease. Gaucher's Disease can, and does, occur among all racial and ethnic groups. It is, however, the most prevalent of the seven primarily Jewish diseases (which include Tay-Sachs, Bloom's Syndrome, Niemann-Pick Disease, Dystonia, Mucolipidosis IV, and Familial Dysautonomia); and is the most common metabolic disorder among Eastern European Jews (Ashkenazi) where an estimated one in 12 persons are carriers.

Gaucher's is caused by a defective gene which renders the body incapable of producing sufficient amounts of the enzyme glucocerebrosidase. In the absence of this enzyme, the body is unable to break-down fatty materials (lipids) which collect excessively in major organs. The effects can be severely debilitating and may appear at any age.

Difficult to diagnose, Gaucher's may begin in early childhood but remain undetected for many years because of the wide range and variety of symptoms. Type I is the most common form of Gaucher's Disease. The accumulation of lipids in the bone marrow causes severe pain and often requires bone and joint replacement. The orthopaedic problems are severely debilitating, dooming many victims to be wheelchair bound. The spleen becomes enlarged from the abnormal storage of lipids in that organ, and may weigh as much as 30 pounds in an adult. In addition, fractures, joint pain, impaired blood clotting, an enlarged liver and liver complications which may be fatal all serve to decrease the quality of the Gaucher patient's life immeasurably.

In its infantile form, Type II, lipids are stored in the brain leading to rapid nervous system deterioration, causing death by age two.

Type III, or Juvenile form Gaucher's, is similar to Type II, but the progression of the disease is slower. Lipids accumulate in the brain causing nervous system problems including retardation, seizures and abnormal eye and body movements. A foreshortened life span may be expected.

In order to produce offspring with Gaucher's, both parents must carry one defective gene. If both parents are carriers, there is a 25 percent chance with each pregnancy that the child will have Gaucher's, and a 50 percent chance that the child will be a carrier.

A simple white blood cell test or a small skin biopsy will determine the presence of Gaucher's, or whether or not someone is a carrier. Since carriers have no signs of the disease, their status can be discovered only through blood and skin tests. Prenatal diagnosis may be made through amniocentesis.

Although a remedy for Gaucher's Disease has not yet been discovered, there are hopeful developments. In 1984, the gene for glucocerebrosidase was identified and cloned by a research team at the National Institutes of Health, headed by Dr. John Barranger. This may make it possible, in future years, to manufacture large quantities of the deficient enzyme through recombinant DNA techniques.

Meanwhile, at N.I.H., glucocerebrosidase extracted from human placenta, purified and chemically modified so that it can be absorbed by the lipid-laden cells, is being administered to a few children in a clinical setting. Until quite recently, the process of obtaining the enzyme has been costly, technically difficult and time-consuming. Currently, collaborative research is being carried out by N.I.H. and the University of Amsterdam. This year, a single-step method for the rapid isolation of a very pure enzyme in extremely high yield was developed at the University of Amsterdam. Through a process called immunoaffinity chromatography, very large amounts of the enzyme can now be obtained in a purification procedure taking only 18 hours.

In a recent letter to the National Gaucher Foundation, Professor J.R. Hobbs, Chairman of the Westminster Bone Marrow Transplant Team, Charing Cross and

Westminster Medical School, London, England, reports that his team has now transplanted five children with Gaucher's Disease with bone marrow implants from matched sibling donors. The progress of four of the children has been extremely encouraging. According to Dr. Hobbs, without exception, all of the children have felt much fitter and stronger; and one patient was able to remove her leg irons, abandon her crutches and is now able to ride a bicycle. It is also reported that children similarly treated in Stockholm and Jerusalem have done extremely well.

Medical research in Gaucher's Disease is at a critical stage. It is entirely possible that research projects currently underway at N.I.H. may lead to a major breakthrough in the near future. Although Gaucher's is a relatively rare disorder, it is being used as a prototype: when a cure for Gaucher's is finally found, it will help to unlock the mysteries of over forty other genetic diseases as well.

The studies which are being conducted at the National Institute for Neurological and Communicative Disorders and Stroke are at a crucial juncture in Gaucher's research. In consideration of the excellent progress being made in Gaucher's research, we urge that it be supported at appropriate levels.

TUESDAY, APRIL 29, 1986.

NIAMSD

WITNESSES

ROBERTA DeVITO, PRESIDENT, AMERICAN BRITTLE BONE SOCIETY
CONGIE DeVITO
ANNA MARIE DeVITO

Mr. NATCHER. Our next witness is Mrs. Roberta DeVito. Come around, Mrs. DeVito. It is a pleasure to have you back before the committee, and you have our friend Congie there with you, and Anna Marie, and the last time that Congie was here, I talked with him and he told me some day, he was going to be President of the United States.

Congie, you keep that in mind. We are going to need you when the time comes.

Mrs. ROBERTA DEVITO. It is nice to be here again, and here today also, I would like to introduce her to you, she has been here in past years, Margaret Canfield, sitting on the end of this row, and Margaret has OI, as does Congie, and I am going to leave the bulk of what we have to say up to our future politician, because I think that the record is a testimony to the fact that he has had amazing success with this committee, because I think he speaks from a vantagepoint that even I cannot speak from.

So, not to bore you with too many details, I want to thank you and bring up the point that the new Institute, the National Institute of Arthritis and Musculoskeletal and Skin Diseases has been established by law, and we are real glad for that, and we hope the funding comes in that is necessary to get the new Institute viable, and all the program service areas are hoping that not too much of a cut is going to have to be made, to make the new Institute viable.

But we are willing to make what sacrifices we have to make this year or two, to get it off the ground. I speak on behalf of brittle bone diseases, OI, and osteoporosis, and at this time, I will turn my talk over to Congie.

[The statement of Mrs. DeVito follows:]

Testimony presented by

Roberta DeVito
President
AMERICAN BRITTLE BONE SOCIETY
1256 Merrill Drive
Marshallton
West Chester, Pennsylvania 19382-1755

in favor of

FY '87 BUDGETING OF SIGNIFICANT FINANCIAL SUPPORT BY THE NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES OF RESEARCH OF THE BRITTLE BONE DISEASES, PARTICULARLY:

OSTEOPOROSIS -- Twenty million older Americans exhibit abnormal loss of bone tissue with resulting skeletal weakness and bone fragility, and

OSTEOGENESIS IMPERFECTA -- Twenty thousand Americans experience varying degrees of this brittle bone syndrome which also affects other body systems.

before the

House Subcommittee on Appropriations --
Labor, Health and Human Serives, Education
and Related Agencies

Tuesday, April 29. 1986

Representative William H. Natcher,
Chairman

SUMMARY OF RECOMMENDATIONS

with respect to the

FY 1987 BUDGET OF NIAMS, NIH

In support of the concensus of the Coalition of Organizations concerned with the programs of the National Institute of Arthritis and Musculoskeletal and Skin Diseases, I suggest funding that is felt to be necessary to maintain research efforts at current service levels.

1. One hundred million dollars for investigator-initiated research grants (RO-1). This support level would fund 223 new grants in FY 1987, and a total of 612 new and continuation grants. At this level, the estimated award rate for new grants would be 34%, with a priority score payline of 170. The $100 million we urge is only 3% greater than the current services level.

2. Funding at current levels for training and contracts. Except, an increase of $2.4 million over current services in Centers funding to support 6 core centers in dermatology. I especially urge initial funding of Specialized Centers of Research (SCORs) to target multidisciplinary research approaches in three areas: osteoporosis, osteoarthritis, and rheumatoid arthritis, as both the House and Senate Appropriations Committee's recommended last year.

3. Reasonable funding of the category which includes Clinical Investigator and Physicican Scientist awards. Both must have emphasis if our research community is to remain viable in future years. No new awards would be possible under the President's FY 1987 budget.

4. Intramural research must be strengthened to complement extramural activity.

continued,
SUMMARY OF RECOMMENDATIONS
Page 2

5. NIH projects for FY 1987 a budget of $4,259,000 for osteogenesis imperfecta and of $5,488,000 for osteoporosis. I recommend that this service level be supported. Except, an increase in funding of osteoporosis research that is commensurate with the seriousness and widespread suffering caused by this aberration of bone metabolism.

6. Another $1.5 million for NIAMS staff over and above the additional $1 million in the President's FY 1987 budget. Under the NIH organization plan for NIAMS, 57 staff members have been slotted for NIAMS. At these personnel levels NIAMS cannot function as an independent Institute. NIAMS requires another 36 personnel.

If $1 million is added for this purpose as is in the President's FY 1987 budget, this will permit the placement of 15 to 20 staff.

Another $1.5 million is necessary to provide the minimum of 36 additional personnel.

Roberta DeVito
President
American Brittle Bone Society

4/29/86

Congressman Natcher:
Members of the Committee:

More than 50 million Americans are affected by arthritis, musculoskeletal and skin diseases. Of these, twenty million have osteoporosis at an annual cost to society of $6 billion. Many thousands more suffer a systemic syndrome known as osteogenesis imperfecta.

Biomedical research, and more specifically, research to improve the lives of these people should be one of the highest of this nation's priorities.

All of these serious diseases or conditions result in morbidity, mortality and disability, which cost the American economy many billions of dollars each year in medical care, lost wages and productivity, lost taxes, increased disability and workers' compensation payments, and increased social services costs.

Research advances in the past decade have brought about improved treatment, control of disease, better diagnostic methods, and important new surgical procedures which strongly indicate that accelerated and targeted research efforts can sharply ameliorate, control, prevent, and cure a number of these diseases. This promise for the future was a major reason for the creation of the new Institute.

The members of this Subcommittee are aware that NIAMS was established in law on November 20, 1985. Fiscal Year 1987 marks the first opportunity for Congress to address research needs of the programs encompassed by this new Institute as a separate budget line item.

The President has supported the creation of NIAMS, and the Congress has endorsed it through several nearly-unanimous votes. I now urge you to appropriate funds for the Institute (as outlined in the Summary of Recommendations) at a level adequate to allow NIAMS to initiate the focussed, national research program contemplated by Congress at the time of its establishment.

continued,
TESTIMONY of ROBERTA DEVITO
Page 2

Conclusion

The Coalition of Organizations, which I support, believes that the amounts it is recommending for FY 1987 are fiscally sound and minimally adequate to make NIAMS operational and effective as an NIH research institute.

There is ample scientific justification for the FY 1987 budget proposed. The loss of momentum in biomedical research through reduced or level funding would mean a serious loss of research opportunity for many years to come and the real potential exists for the loss of an entire generation of investigators.

We urge Congress to enact, and the President to approve, appropriations for FY 1987 at the level the Coalition recommends, as the minimum necessary to firmly establish NIAMS and to begin the level of research effort essential to finding the answers to the diseases addressed by the National Institute of Arthritis and Musculoskeletal and Skin Diseases.

I thank you for the opportunity you have given me to appear before this Committee.

4/29/86

Mr. NATCHER. Congie, go right ahead, we will be pleased to hear from you.

Mr. CONGIE DEVITO. I would like to say how much I enjoyed the opportunity to be here presenting testimony before this committee. I am also probably getting some good experience a long the way to the day I get to sit in one of your chairs.

Getting serious, the older I get, the more I recognize how important a job I have, because I know that what I represent is a lot more people than just me. I know they are depending on me.

I'm taking my appearance here a lot more seriously, because you are listening to me and acting on my request for more funding of my brittle bone disease and osteoporosis, too. For this, I would like to thank you for showing how much you are concerned about me.

Each year, this committee has taken a leading role to see that there is growth in funding for research. Now, in fiscal year 1987 the NIH projects a budget of $4,259,000 for OI research, and I am asking that you make sure that this amount does not get cut when you mark up the budgets.

I really feel that you will keep me in mind when you get down to the hard work of preparing the budget, and I hope you can convince the Congress that the money they spend on OI is worth it.

Because I am worth it. Thank you.

Mr. NATCHER. Congie, you made a good statement. We want you to take good care of yourself now. I served with seven Presidents, Congie, and I want to serve with you. Thank you very much, and we appreciate your appearance.

Anna Marie, we appreciate your coming in, too.

Mr. CONTE. I would like to congratulate you for the very, very thoughtful and well-addressed statement that you made here today. You have a bright future ahead of you, and we are proud of you.

Mr. CONGIE DEVITO. Thank you.

Mr. CONTE. We will get all the money we can for this research.

Mr. NATCHER. Thank you very much.

TUESDAY, APRIL 29, 1986.

DIABETES CONTROL PROGRAM OF THE CENTERS FOR DISEASE CONTROL

WITNESS

DR. STEWART M. HAMILTON, OHIO DIABETES TASK FORCE

Mr. NATCHER. Our next witness is Dr. Stewart Hamilton, and we will be pleased to hear from you at this time.

Dr. STEWART HAMILTON. Thank you for the opportunity to testify before you today. I am Dr. Stewart Hamilton of Cleveland, Ohio, a practicing endocrinologist and Medical Director of the International Diabetes Center at Marymount in Cleveland.

I have been actively involved in the care of individuals with diabetes mellitus for 15 years in both academic and private practice, and in several countries of the world.

In 1982, I became the voluntary Chairman of the Ohio Diabetes Task Force, a body set up through the Ohio Department of Health to assist and coordinate the efforts of the Diabetes Control Program of the Centers for Disease Control. I am testifying today in my capacity as the Chairman of the Ohio Diabetes Task Force.

I know that this subcommittee has had previous testimony with regard to the successes of the National Diabetes Control Program of the Centers for Disease Control and their relevance to our national well-being.

In the United States, it is estimated that 11,000,000 individuals have diabetes mellitus, with an annual incidence of new cases of approximately 6 percent. Diabetes is a family disease, and everyone in the family is affected.

In 1980, it has been estimated that 850 major birth defects, 5,800 cases of blindness, 4,000 cases of kidney failure, 31,000 amputations, 23,000 strokes, and 85,000 cases of coronary artery disease arose as new complications of diabetes in the United States.

Over 50 percent of these complications are estimated to be preventable by the type of interventions proposed, propounded, and provide by the Diabetes Control Program of the Centers for Disease Control.

The goal of the Centers for Disease Control program is to improve the quality of care that is provided to people with diabetes to reduce the morbidity, mortality and cost associated with the preventable complications of diabetes.

States have designed and are implementing coordinated community control strategies that build on the existing scientific base and incorporate current diabetes treatment recommendations into existing systems of care.

During the past year, major emphasis has been given to preventing four major causes of morbidity among people with diabetes: Diabetic eye disease, adverse outcomes of pregnancy, lower extremity amputations, and hypertension.

With additional funds that were appropriated in 1985, 12 States are now engaged in special programs to prevent visual loss among persons with diabetes. Five of these States are receiving Federal diabetes control program funds for the first time.

States will identify patients at high risk for retinopathy, will assure that their eyes are examined for retinopathy, cataracts, and glaucoma, and will refer patients for necessary treatment.

The timely diagnosis of vision-threatening retinopathy and referral for treatment can significantly reduce the risk of blindness. Related programs have shown the value of these preventive measures.

In Mississippi, 337 persons with diabetes were examined at a community health center as part of a special clinic program. To date, 28 persons have required treatment for proliferative retinopathy alone. In the absence of a screening and referral program, most of these patients would not have received timely treatment to prevent the subsequent loss of vision.

Evidence for the efficacy of improving pre-conception care for diabetic women comes from a California regional maternal and child health program that receives funds from the California Diabetes Control Program.

On the basis of 103 deliveries, major congenital anomalies occurred among 14 percent of the offspring of women who began prenatal care in the first trimester compared with 2 percent of the offspring of women who began care before conception.

The National Diabetes Control Program also focuses on patient and professional education to reduce the impact of diabetes.

Reductions in hospital admissions and average length of stay following outpatient education programs in Maine, Michigan and Rhode Island have provided the impetus for securing third-party reimbursements for these diabetes education services from Blue Cross-Blue Shield, medicare and medicaid, and other third-party payers in several States.

Other activities of the National Diabetes Control Program include:

Public health strategies and guidelines developed in consultation with leaders in diabetes to provide the technical basis for program development.

Networks for transferring program findings and research advances into community practice.

Linkages with related public health programs, primary care providers and third-party payers.

Promotion of national standards of care developed for health professionals, including the National Standards for Diabetes Patient Education Programs, that were prepared under the aegis of the Board.

An outcome-oriented evaluation system that is ready for feasibility testing.

As you may know, the Centers for Disease Control Diabetes Control Program has two important components: A central "core" staff, based in the Centers for Disease Control headquarters in Atlanta, Georgia; and a field demonstration components program, which is currently active in more than 20 States, including Kentucky, Ohio, California, Michigan and Maryland.

In the proposed budget of fiscal year 1987, the "core" staff will receive $2,400,000, as in previous years. However, unlike previous years, the Administration has deleted the $5,000,000 usually allocated for the field demonstration components, together with their 20 public health advisory positions.

I am here today to ask for the support of the subcommittee to restore these $5,000,000 to the fiscal year 1987 budget.

Our request for this support is based on the unexpected, but gratifying evolution of the field demonstration components to a role which has become much larger and more important than that initially envisioned when the Centers for Disease Control Diabetes Control Programs were first organized.

The original intent of these field demonstration components was to provide isolated models of diabetes care which, by example, would influence patterns of care in the localities in which they existed.

However, in association with the "core" staff, these field demonstration components have grown to become the focus of the enlarging and vigorous national effort to improve diabetes care and health care delivery "setting the pace" for advances in many States.

The national leadership role has now become essential to the overall success of our efforts to stop the adverse social and economic impacts of diabetes on our population and its value far exceeds that originally expected for the field demonstration components.

The Centers for Disease Control Program has shown that public health intervention in community settings are effective in reducing morbidity and mortality associated with the complications of diabetes. Substantial reductions in diabetes-related hospitalization costs have already been documented.

Community programs to prevent severe visual loss from diabetic eye disease have been initiated and similar programs are planned for amputations, adverse outcomes of pregnancy, and hypertension in people with diabetes.

We can anticipate substantial reductions in the complications of diabetes on the basis of existing scientific information and the development of effective community initiatives.

It is, therefore, appropriate to evaluate the importance of the field demonstration components in light of their current, rather than their original role. Based on their perceived importance by the diabetes community, they have achieved widespread support throughout the United States.

The support and interest shown by your subcommittee and Congress for the efforts of the Centers for Disease Control and its Diabetes Control Program have been, and are, greatly appreciated by many of your constituents.

We ask your continued help and support to restore $5,000,000 to the fiscal year 1987 budget to continue the pivotal and economically vital work of the field demonstration components and the 20 public health advisory positions linked to them.

Thank you for your time and attention.

Mr. NATCHER. Dr. Hamilton, you have made an excellent statement. We appreciate your appearance before the committee.

TUESDAY, APRIL 29, 1986.

HEALTH PROFESSIONS

WITNESS

WILLIAM J. KINNARD, DEAN, SCHOOL OF PHARMACY, UNIVERSITY OF MARYLAND AT BALTIMORE, FEDERATION OF ASSOCIATIONS OF SCHOOLS OF THE HEALTH PROFESSIONS

Mr. NATCHER. Our next witness is Dr. William J. Kinnard, and we will be pleased to hear from you at this time, Doctor.

Mr. KINNARD. Thank you, Chairman Natcher, and Congressman Conte, and Congressman Hoyer.

I am Dean of the University of Maryland School of Pharmacy and past President of the American Association of College Pharmacies.

I am pleased to represent the Federation of Associations of Schools of the Health Professions today and talk about the appropriations issue.

The Federation of Associations of Schools of the Health Professions represents some 300,000 students and 35,000 faculty and some

1600 schools of the health professions throughout the United States and Puerto Rico, and we are greatly concerned about the impact of the threatened budgetary cuts on our program.

Certainly our members who represent nursing, optometry and many others, cover a wide range of services to this country. Members of the Federation are going to talk in more detail.

I have a couple of comments in general about the problem. We all feel that these cuts will have a significant impact on the ability of schools to generate students to meet health care demands, and in turn, we are going to have a decrease in the level, the quality of care to the citizens of this country.

The President's budget and his decisions appear to be based on two issues: One, they believe we have enough health professionals to go around; and two, they believe the health care system is the same old system; and neither of those are true, and we should not attempt to tinker with what I call the far side of the supply for health professionals.

That is, the educational component. Today's health care system is in a revolutionary state. We have seen major changes, and I am not sure everyone is aware of them.

The changes in the cost containment issues related to hospital care, for example, the pre-admission controls, the DRGs, the other issues that are restraining those costs, have changed the population of patients within those hospitals.

We now are seeing greatly increased—a great increase in intensification of care, patients in those hospitals, and it is not the old hospital where we saw a full range of patients.

One of my people said within a few years, that teaching hospital is going to be one large surgical ICU, and we will demand highly specialized care.

On the outside of the hospitals, we are seeing a change in care, home health care, ambulatory care programs mushrooming, and we don't have the health professionals to meet those demands.

Couple that with the recognition of the drain of society, and the problems we see in deinstitutionalization of the mentally retarded patient and other issues, we are getting stretched as schools to beyond the breaking point, so we need to go back to the issue of let's not tinker with the system.

Earlier this year, the Assistant Secretary for Administration of HHS came and addressed the Council Deans of our Association, and he said all major studies of supply and demand for health professionals conclude that virtually all occupations are in excess supply, and that this will continue for the remainder of the decade.

I want to tell you that that statement by the Assistant Secretary caused such a stir in our Association, because just in pharmacy alone, we are in the greatest shortage period that I have ever seen.

I have been in education 30 years, and we have got the greatest shortage of health professionals in pharmacy we ever had, whether in Maryland, Kentucky, wherever it is, we have got problems.

That is just one area, not just shortage of total professionals, but shortage of people to do the specialized care we need. Some of the people that were here earlier that need specialized services, and everything that the budget suggests is that we will lose support of special programs in the health professions and nursing student loans, and the HEAL program, and we cannot afford it.

Students that go to schools in our Federation quite frankly come from lower-income areas than those that go into medicine and dentistry, and we need the support for these students. They don't come from families with a lot of money.

Our effort to bring minorities, students from deprived areas, needs this kind of support. We can't afford to step back at all from it.

The future dimension of the health manpower demands are going to be influenced by the changing health needs, and we are going to influence—the health needs are going to influence the manpower demand.

It goes both ways. We need the kind of flexibility for our programs to allow these changes in the health care.

For those reasons, the Federation recommends that we maintain the level of fiscal year 1986 appropriations for the programs authorized in Title VII and VIII of the Public Health Service Act, and Title IV of the Higher Education Act.

We recognize we are in a time of tight constraint, and we think it is a joint effort between you here on the Hill and us in education, so that we can meet the manpower demand.

Mr. NATCHER. Dr. Kinnard, we want to thank you for your appearance before the committee. You made an excellent statement.

[The statement of Mr. Kinnard follows:]

FEDERATION OF ASSOCIATIONS
OF SCHOOLS OF THE HEALTH PROFESSIONS
6110 EXECUTIVE BOULEVARD, SUITE 204, ROCKVILLE, MD 20852 / (301) 984-9350

STATEMENT OF THE

FEDERATION OF ASSOCIATIONS
OF SCHOOLS OF THE HEALTH PROFESSIONS

BEFORE THE

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,
AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES

PRESENTED BY

WILLIAM J. KINNARD, JR., PH.D.

APRIL 29, 1986
11:00 A.M.

RE: Health Professions Educational Assistance Programs

MEMBER ORGANIZATIONS

American Association of Colleges of Nursing • American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy • American Association of Colleges of Podiatric Medicine
Association of American Veterinary Medical Colleges • Association of Schools and Colleges of Optometry
Association of Schools of Public Health • Association of University Programs in Health Administration • National League for Nursing

Mr. Chairman and Members of the Subcommittee:

My name is William J. Kinnard, Jr., Ph.D., and I am Dean of the School of Pharmacy at the University of Maryland. I am pleased to be here today to present the views of the Federation of Associations of Schools of the Health Professions (FASHP) on appropriations for fiscal year 1987 for federal programs of support for health professions education. This includes student assistance and grants to institutions under Titles VII and VIII of the Public Health Service Act.

FASHP represents over 300,000 students and 35,000 faculty in some 1600 schools located throughout the United States and in Puerto Rico. These schools play a key role in assuring adequate health resources and research capabilities necessary to maintain the health of the people in this country -- the young and old of all income strata living in urban and rural settings. Members include colleges of nursing, osteopathic medicine, pharmacy, podiatric medicine, veterinary medicine, optometry, public health and health administration.

Some of our member associations will be testifying on appropriations separately and will speak in depth about their special concerns. Therefore, I will confine my comments to an overview of mutually shared concerns.

Mr. Chairman, the President's budget for fiscal year 1987 proposes to eliminate funds for health professions training grants under Titles VII and VIII of the Public Health Service Act. This action is premised on the belief that all health professions are in oversupply. That is simply not the case.

Available data show continuing, and in some cases increasing, shortages of many types of health professionals. FASHP believes that these manpower shortages can best be addressed by the professions working with the federal government in a cooperative partnership. This has been the case in the past, and we urge that it continue.

Let me cite some of the studies that demonstrate a continuing need for manpower development among many health professions.

. A DHHS report and the 1979 Surgeon General's Report, "Healthy People," substantiate that the need for public health professionals could double between 1980 and 1990. There are current critical shortages of epidemiologists, biostatisticians and environmental health, health finance and economic specialists, as well as a serious shortage of competent managers for low cost alternative delivery systems.

. Nurse administrators and nurse educators are in particularly short supply nationwide where the percentage of graduate degrees is significantly less than other professions. This is confirmed by an Institute of Medicine study projecting that the supply of nurses with graduate degrees in 1990 will be less than half of projected needs.

. DHHS has identified more than 1400 podiatric shortage areas in this country as well as projected shortages of podiatrists into the 1990s. Today there is only one podiatrist for every 27,000 Americans.

. In 1984 a federal government manpower study indicated that only if enrollments remain at current levels would a good balance between future supplies and demands for pharmacists be maintained. Enrollments in pharmacy schools, however, continue to decline. Perhaps a more important measure for future manpower supplies is data showing numbers of pharmacy school graduates continuing to decline. In 1977 pharmacy graduated 8,011 students and in 1985, only 5,755 degrees were conferred.

. A 1982 optometric manpower report concluded that there will continue to be a shortage of optometrists projected to be nearly 9,000 by the year 1990.

. The delivery of primary care services has been designated as a high priority area by the Department of Health and Human Services (DHHS). Due in part to federal support, over 80 percent of osteopathic medical students have gone on to provide primary care services.

Not only is there a need to increase the numbers of many types of health professions, but particular attention needs to be paid to what types are needed and how they are trained. This is essential if we are to be responsive to changing modes of health care delivery and evolving medical needs. I have already noted the need for primary care physicians, but let me cite some others.

. Nursing is attempting to provide advanced degree nurse clinicians able to provide more cost effective direct patient services in acute care hospitals, community agencies and long-term care settings.

. Physicians are facing increased demands on their prescribing habits as a result of rapidly changing technologies and the availability of more potent and complicated medicines. This demand has created a need for more clinically educated and trained pharmacists.

. Changing patterns of health care organizations and practice have resulted in a growing demand for well-trained health administrators for home health agencies, long-term care facilities, rural hospitals and HMOs. Yet it is estimated that two-thirds of the nation's health administrators lack sufficient education and management skills training for their jobs. Unless this situation is remedied, national efforts at cost containment will be weakened and hospital facilities and health professionals will function less productively.

. The "graying of America" has created a demand for all health professions to focus on increased training in geriatrics and to be innovative in changing traditional approaches to serving this expanding segment of the population.

. The need for medical care continues to be particularly severe among the 59 million Americans living in rural areas of the country. Additional primary care physicians and other health professionals have been identified by the federal government as the resources necessary to fulfill these long-standing demands.

The programs cited under Titles VII and VIII of the Public Health Service Act enable our educational institutions to work with the government in order to respond to these needs. These problems are national in scope and should be addressed at the federal level.

Continued funding for these grant programs helps solve only part of the problem. Applicant pools and enrollment in the health professions continue to decline as a result of increased costs of education and student indebtedness. Minority and disadvantaged populations are severely underrepresented. If students are to continue to have opportunities to study in the health field, various forms of financial aid must be continued.

We are particularly concerned about the following:

. Health Professions Student Loan (HPSL) and Nursing Student Loan (NSL) Programs. HPSL and NSL monies are focused only on those students with exceptional financial need. Cutbacks in this program would have long-term, negative effects by curtailing recruitment of minority and other disadvantaged students.

. Health Education Assistance Loan (HEAL) Program. Annual tuition costs for all health professions schools generally range from $10,000 - $15,000. In an environment of growing constraints on other health professions loan programs and an annual ceiling of $5,000 under the Guaranteed Student Loan Program, schools are increasingly forced to include HEAL money as part of their students' financial aid package. DHHS' Bureau of Health Professions reports that HEAL loan volume increased by $50 million between 1984 and 1985. Clearly this program is important. Its elimination or unrealistic reduction would render health professions training unattainable for many well qualified students.

Other loan programs under the Higher Education Act, such as Guaranteed Student Loans, PLUS and the National Direct Student Loans, are also of concern. Efforts to reduce the size of these programs have reduced their availability to students.

In conclusion, Mr. Chairman, let me note that the dimension of future manpower demands will be influenced by changing health needs. In planning to meet those demands, policy makers must consider the necessary supply of all health professionals and the interaction, interdependency, and, in some cases, the interchangeability among professionals.

The health professions and government share responsibility to strive for the best health care system possible. To deny resources to one portion of the partnership is to risk the loss of opportunities in prevention and cost containment, and underservice to groups with special needs such as the elderly, the economically disadvantaged and rural Americans.

For these reasons, Mr. Chairman, the Federation recommends that adequate funding levels be provided for health professions programs as authorized in Titles VII and VIII of the Public Health Service Act and Title IV of the Higher Education Act.

TUESDAY, APRIL 29, 1986.

FAMILY MEDICINE AND RESIDENCY

WITNESS

DR. T. BYRON THAMES, BOARD MEMBER, THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

Mr. NATCHER. Our next witness is Dr. T. Byron Thames. We are delighted to have you before the committee, and we will be pleased to hear from you.

Dr. THAMES. Thank you, Mr. Chairman. I am T. Byron Thames, a practicing physician.

The American Academy of Family Physicians appreciates the opportunity to appear before you to testify in support of maintaining funding for family practice training programs. Again, this year, family practice training is threatened by the Administration's proposed elimination of all Public Health Service funding the health professions education programs.

The strong support of this subcommittee for these programs has enabled this specialty to remain viable in spite of dwindling economic resources. Your continued support of these programs is critical as Congress faces increasingly difficult budget decisions.

Last year, Congress passed a three-year reauthorization of the Health Professions Training Assistance Act, Public Law 99-129, which contains funding provisions for primary care training programs under the Public Health Service Act.

A three-year commitment to continue family practice and other primary care training was made because Congress recognized the need to continue targeted Federal support for such training.

We believe that the fiscal year 1987 appropriation should be the same amount called for in the Health Professions Training Assistance Act, which provides a small increase over the fiscal year 1986 level in section 786 and freezes section 780 funding.

These amounts received careful Congressional scrutiny during the debate on the reauthorization of the health professions bill, and were determined to be adequate to sustain current training programs.

The Administration's proposal, on the other hand, would ignore the will of Congress by terminating all Federal assistance to these programs, thereby jeopardizing the residency training of family physicians and disrupting the future delivery of primary health care in America.

Family physicians are not among those specialties projected to be in oversupply by 1990. Furthermore, if the decline in family practice residency programs continues, we suggest there may be a shortage of family physicians by 1990.

Financial constraints, such as those proposed by the Administration, inevitably will result in more program closures and a reduction in the training of family physicians.

The fifth report also estimates that about 14,000,000 persons, or 6 percent of the U.S. residency population remain underserved in the Nation's primary care health manpower shortage areas.

Many family practice residency graduates locate and practice in underserved areas, both inner city and rural areas.

For example, among 1985 family practice residency graduates, approximately 50 percent entered practice in communities with populations of 25,000 or less, and 70 percent of these communities are not within 25 miles of a large city.

This compares with approximately 11 percent of physicians in other specialties who enter practice in non-metropolitan areas.

Family physicians have been selected by the National Health Service Corps as uniquely qualified to perform in health manpower shortage areas.

We believe the country continued to need well-qualified family physicians who provide cost-effective, preventive care in an ambulatory setting.

We feel these family physicians are currently providing care to a significant segment of the elderly population.

We believe that current proposals to reduce or eliminate family practice education funding are short-sighted and ignore long-term health care policy. The Council should be allowed to make its assessment and offer its recommendations so the delivery of health care is not irrationally disrupted.

For the past decade, Congress has targeted family practice for financial support. And such government support is essential to maintain the progress that has been made in this discipline. Without direct Federal support, many of these family practice residencies will not survive.

Family practice training is a combination of ambulatory and in-hospital training, with the emphasis on ambulatory. Due to this emphasis, family practice programs incur considerable expenses outside the hospital setting which are not reimbursed by medicare or other third-party payers on a cost basis through the hospital.

In addition to higher costs, the income of family practice training programs is lower.

Facing intense budget constraints, teaching hospitals will have fewer incentives to retain family practice and other primary care training programs. The Federal grants provided by the Public Health Service help offset some of these financial disincentives.

The American Academy of Family Physicians is sensitive to the financial constraint faced by the Congress. We share the concern of Congress that Federal funds be expended responsibly and that Federal resources not be used to duplicate programmatic efforts by other levels of government or by the private sector.

For family practice training programs, elimination of Federal support will result in elimination of programs. In view of the need for well-qualified physicians to provide comprehensive, cost-effective, ambulatory based primary care services, we believe that continued Federal support to family practice training programs is a sound investment in the future of our Nation's health.

We respectfully request the appropriation level for family practice programs be the same as that authorized for the fiscal year 1987.

Mr. Chairman, I thank you very much for the opportunity to testify before you on behalf of the 58,000 members of the American Academy of Family Physicians.

Mr. Natcher. Dr. Thames, thank you, you have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Dr. Thames follows:]

TESTIMONY OF THE
AMERICAN ACADEMY OF FAMILY PHYSICIANS
BEFORE THE
SUBCOMMITTEE ON LABOR-HHS
HOUSE COMMITTEE ON APPROPRIATIONS
CONCERNING FUNDING FOR FAMILY PRACTICE TRAINING PROGRAMS

Presented by

T. Byron Thames, M.D.

April 29, 1986
11:10 a.m.

My name is T. Byron Thames, M.D. I am a practicing family physician from Orlando, Florida, and currently serve on the Board of Directors of the American Academy of Family Physicians and chair the organization's Commission on Legislation and Governmental Affairs.

The American Academy of Family Physicians appreciate the opportunity to appear before you to testify in support of maintaining funding for family practice training programs. Again, this year, family practice training is threatened by the Administration's proposed elimination of all Public Health Service funding to health professions education programs. The strong support of this subcommittee for these programs has enabled this specialty to remain viable inspite of dwindling economic resources. Your continued support of these programs is critical as Congress faces increasingly difficult budget decisions. And in view of the track record of family practice programs, whose success has brought primary health care to millions of Americans, your continued support is justified.

As you are aware, last year Congress passed a three year reauthorization of the Health Professions Training Assistance Act, P.L. 99-129, which contains funding provisions for primary care training programs under the Public Health Service Act. A three-year commitment to continue family practice and other primary care training was made because Congress recognized the need to continue targeted federal support for such training. Section 786 of the Act provides authorization levels of $36 million, $37 million and $39.4 million in FYs 1986-1988 for grants to support residency training programs in family practice, faculty development and predoctoral training programs in family medicine (with 7.5% for general dentistry). The funds authorized by Section 786 have been used to establish, to maintain and to improve family practice residency programs. These funds currently support 180 graduate projects, 62 predoctoral projects and 49 faculty development projects, totalling 301. Another section of the Act, Section 780, authorizes grants to schools of medicine to establish, maintain and/or improve academic and administrative units to provide clinical instruction in family medicine. The three year authorization amount for this Section is

$7 million per year. This amount currently supports 61 projects. Appropriation levels for FY 1986 were the same amounts authorized in the Act.

We believe that the FY 1987 appropriation should be the same amount called for in the Health Professions Training Assistance Act, which provides a small increase over the FY 1986 level in Section 786 and freezes Section 780 funding. These amounts received careful Congressional scrutiny during the debate on the reauthorization of the Health Professions bill and were determined to be adequate to sustain current training programs. According to the October 3, 1985 floor statement of Henry A. Waxman, Chairman of the House Energy and Commerce Subcommittee on Health and the Environment, "Funding levels in this bill are quite modest. The total authorizations are frozen at the 1985 appropriations level for 1 year. For the 2 subsequent years, funding is permitted to increase at rates of 2.7 percent and 2.3 percent, respectively, or about one-half of the level estimated by the CBO as necessary to continue current services." Although the amounts are not large in terms of the overall budget, they have a significant impact on the ability of family practice training programs to continue to operate.

The Administration's proposal, on the other hand, would ignore the will of Congress by terminating all federal assistance to these programs, thereby jeopardizing the residency training of family physicians and disrupting the future delivery of primary health care in America. The Administration's rationale for discontinuing the health professions training programs is based on a projected national surplus of health professions by 1990 and improved geographic distribution. We believe these conclusions over-generalize and are driven by efforts to cut the budget. A recent report of the Bureau of Health Professions, "Fifth Report to the President and Congress on the Status of Health Personnel in the United States (March 1986)," notes "a continuing decline in the percentage of general/family practitioners (as a proportion of all physicians)." Data compiled by the Academy indicates that the number of residents in family practice programs in July 1985 was 7,486, exactly the same number as in 1984. Since its peak in 1983, the number of accredited family practice residency programs has decreased by ten. Family physicians are not among those specialties projected to be in oversupply by 1990. Furthermore, if the decline in family practice residency programs continues, we suggest there may be a shortage of family physicians by 1990. Financial constraints, such as those proposed by the Administration, inevitably will result in more program closures and a reduction in the training of family physicians.

The Fifth Report also estimates that about 14 million persons or 6 percent of the U.S. residency population remain underserved in the Nation's primary care health manpower shortage areas. Many family practice residency graduates locate and practice in underserved areas—both inner city and rural areas. For example, among 1985 family practice residency graduates, approximately 50% entered practice in communities with populations of 25,000 or less and 70% of these communities are not within 25 miles of a large city. This compares with approximately 11% of physicians in other specialties who enter practice in non-metropolitan areas. Many of these areas seek family physicians over other specialists because of their training.

Family Physicians have been selected by the National Health Service Corps (NHSC) as uniquely qualified to perform in health manpower shortage areas. The Director of the National Health Service Corps, Kenneth Moritsugu, M.D., in explaining the NHSC preference for assigning family physicians to rural areas, has stated in a letter to the AAFP, "Family Physicians, by virture of their training, are capable of providing the full spectrum of primary care to all family members, in both urban and rural settings. They are the compleat physicians who can practice pediatrics, internal medicine, obstetrics and gynecology, general surgery and psychosocial medicine. For this reason, family physicians are the most capable specialists for the provision of primary health care in areas where complementary specialty backup may not be present. These statements cannot be made for any of the other specialties available to the NHSC, because they must rely on other specialists to provide the full complement of primary care for the family." We believe the country continues to need well-qualified family physicians who provide cost-effective, preventive care in an ambulatory setting. Family practice residency programs, therefore, fulfill an essential societal need, producing well-qualified family physicians able to provide cost-effective, comprehensive and continual care to all members of the family regardless of age, sex or medical condition.

Family physicians are currently providing care to a significant segment of the elderly population and will continue to do so at an increasing rate as the age of their patients increases. Furthermore, due to extended life expectancy, it is predicted that there will be an increased demand for services of qualified health personnel trained in geriatrics. Because family physicians are trained to treat the entire family, they are exceptionally qualified to administer to the majority of the elderly population's health care needs. Geriatric health care has been and continues to be an essential element in family practice training programs.

Congress recently passed the Consolidated Omnibus Budget Reconciliation Act, H.R. 3128, which establishes a Council on Medical Education. The Council is directed to make recommendations to the HHS Secretary and Congress regarding the current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties. This is to include appropriate federal policy concerning changes in the financing of undergraduate and graduate medical

medical education programs. We believe that current proposals to reduce or terminate family practice education funding are short-sighted and ignore long-term health care policy. The Council should be allowed to make its assessment and offer its recommendations so the delivery of health care is not irrationally disrupted.

For the past decade, Congress has targeted family practice for financial support. Government support for family practice programs over the past decade is largely responsible for the development and growth of the specialty. And such government support is essential to maintain the progress that has been made in this discipline. Without direct federal support many of these family practice residencies will not survive.

Why won't they survive without direct federal subsidy? The reasons are due to the unique characteristics of family practice residencies that affect their expenses and income. Most postgraduate medical training is hospital-centered. Family practice training is a combination of ambulatory and in-hospital training, with the emphasis on ambulatory. Due to this emphasis, family practice programs incur considerable expenses outside the hospital setting which are not reimbursed by Medicare or other third party payers on a cost basis through the hospital.

In addition to higher costs, the income of family practice training programs is lower. Inherent in the Medicare program are significant payment differentials between physicians cognitive and procedural services, between physicians of different specialties providing similar services and between rural and urban areas. The existing reimbursement system discourages the type of care it should be encouraging--preventive, comprehensive, ambulatory-based care--while rewarding procedurally-oriented, inpatient, episodic care. Those skills and procedures which are taught to family practice residents, and which emphasize ambulatory care and disease prevention, contribute to better health and more cost-effective health care, but do not generate patient care revenue sufficient to underwrite graduate training in family medicine. Consequently, while traditional theory holds that approximately one-half of graduate medical education programs costs should be recovered through income from patient care services, reality shows that this is an unrealistic expectation for family practice. Current data indicate that revenues from patient care provide only 30 percent of the funding for family practice residency programs. Hospital and public dollars support the remainder. Facing intense budget constraints, teaching hospitals will have fewer incentives to retain family practice and other primary care training programs. The federal grants provided by the Public Health Service help offset some of these financial disincentives.

The American Academy of Family Physicians is sensitive to the financial constraint faced by the Congress. We share the concern of Congress that federal funds be expended responsibly and that federal resources not be used to duplicate programmatic efforts by other levels of government or by the private sector. For family practice training programs, elimination of federal support will result in elimination of programs. In view of the need for well qualified physicians to provide comprehensive, cost-effective, ambulatory based primary care services, we believe that continued federal support to family practice training programs is a sound investment in the future of our nation's health. We respectfully request the appropriation level for family practice programs be the same as that authorized for the fiscal year 1987.

TUESDAY, APRIL 29, 1986.

MINORITY HEALTH PROFESSIONS

WITNESS

DR. LOUIS SULLIVAN, VICE PRESIDENT, THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

Mr. **NATCHER.** Our next witness is Dr. Sullivan, and we will be pleased to hear from you.

Dr. **SULLIVAN.** Thank you very much.

Mr. Chairman, Mr. Conte, Mr. Stokes, Mr. Hoyer, I represent the Association of Minority Health Professions Schools, and I am very pleased to appear before you to discuss funding for health professions training and minority research, and to respond to the President's budget proposals for fiscal year 1987 for these programs.

The Association of Minority Health Professions Schools includes the Morehouse School of Medicine, Xavier University College of Pharmacy, Meharry Medical and Dental Colleges, Florida A&M University College of Pharmacy, Texas Southern University School of Pharmacy, Charles R. Drew Postgraduate Medical School and Tuskegee Institute of Veterinary Medicine.

The eight institutions of our Association have graduated 43 percent of the Nation's black physicians and dentists, 50 percent of the Nation's black pharmacists, and 90 percent of the Nation's black veterinarians.

Each of our institutions and the students who attend our schools rely heavily upon Federal institutional and student aid programs. The collective and individual goals of our institutions to increase the number of black and other minority health professionals in the Nation are affected profoundly by your subcommittee's recommendations.

Mr. Chairman, for fiscal year 1987, the President's proposals are not realistic. It is difficult for us to take these proposals seriously when the President and the Office of Management and Budget do not seriously examine the real health status gap among blacks and whites in this Nation, and the co-existing disparity among health professionals.

Currently, black infants are twice as likely to die in their first year as are white infants. Life expectancy for blacks is significantly lower than that of whites. Similarly, blacks suffer a disproportionately high incidence of certain types of cancer, hypertension, diabetes and other disorders.

The Administration has demonstrated its callous views towards the goals of establishing a degree of parity among blacks and whites in health status, and its acute misunderstanding of the health and education disparities that exist in the Nation by proposing a zeroing out of over $150,000,000 in funding for health professions and research support in fiscal year 1987.

Earlier, Congress denied the Administration further budget cutting wishes for recision of most of these resources for fiscal year 1986. We appreciate your support in this regard, Mr. Chairman.

It is critical to maintain funding for all health professions support in fiscal year 1987. Exceptional Need Scholarships, Financial

Distress Grants, Health Professions Student Loans, Disadvantaged Assistance, AHEC, and National Health Service Corps Scholarships are all programs that must be maintained at current service levels, or in some cases modestly increased.

These bare-bone programs are the genuine base of financial support for our students and our institutions. I do not believe we can squeeze any more out of these programs.

Because of a lack of Federal resources, many students have turned to HEAL loans as a last resort. In a time when these funds are being sought after the most, the Administration has proposed that Federal guarantees for HEAL loans be reduced by $150,000,000.

Mr. Chairman, this does not make sense, and we recommend the current limit of $250,000,000 in loan guarantees be maintained. We further strongly oppose the proposed 8-percent premium on HEAL loans. These loans are already very costly, and an additional 8 percent would make them much more unattractive, and unattainable for many low-income minorities.

The Department of Health and Human Services recently administratively established an Office of Minority Health under the Assistant Secretary for Health office.

The charge of this office is to recommend Federal policies which seek to reduce the significant health status disparity among blacks and whites and to implement those policy recommendations made by the HHS Secretary's Task Force on Black and Minority Health.

But we seriously question how the Administration can recognize the severe problem of health status by establishing this office while proposing a budget that completely wipes out all of the programs that provide resources to the institutions that train minority health professionals, or eliminates grants and loans to minority students who attend our institutions.

It has been documented that the best means of closing the health status gap is access to health care for minorities. Black health professionals, trained at minority institutions are more likely to locate their practices in areas that are more heavily populated by blacks and other low-income minorities, thus providing this access.

The Administration's proposal run completely opposite to this reasoning. Their weak response to the significant health status gap, and health professions disparity, is to open a small office of minority health and shut everything else down.

Believe me, Mr. Chairman, this will not work. While we support the establishment of this important Office of Minority Health, and believe it should be well funded as a line item at OASH, it is not yet the answer to all minority health problems.

A significant number of our students rely upon student aid resources through the Department of Education. The proposed budget reductions of nearly $1,500,000,000 in student aid will have a negative impact on all students seeking to further their educational status.

A very bright spot in recent years has been our institutions working individually and collectively with the National Institutes of Health to develop a research base and enhance our research infrastructures.

The Research Centers at Minority Institutions Programs, RCMI, that was created by your subcommittee at the prompting of Congressman Louis Stokes, has become vital to each of our schools, and is making a significant contribution to our institutional research capabilities.

These grants will allow our schools to accelerate our initiatives to train minorities in research methodology, expand existing investigative departments, compete for research dollars, and most importantly, to research health problems that are common to blacks and other minorities.

The benefits of this program to the Nation in health status of minorities alone are obvious. Mr. Chairman, this initiative is making a big difference. We urge you to continue your support of the Research Centers at Minority Institutions, and provide for a modest growth rate of this program.

Our Association has begun to work closely with the National Heart, Lung and Blood Institute and the National Institute of Diabetes, Digestive and Kidney Diseases to secure research funds through their various granting mechanisms to address specific programs or health concerns that are within the purview of their Institute. These efforts are going very well, and we commend each Institute for their cooperation.

The Association is concerned that the Administration's proposal for fiscal year 1987 would end the Biomedical Research Support Grant, BRSG, program at NIH.

BRSG provides more than $200,000,000 in support for research activities. We encourage the committee to provide for continuation of this program and further would like to encourage the committee to include the Research Centers at Minority Institutions program as a grant or cooperative agreement that qualifies an institution to be eligible to apply for Biomedical Research Support Grants.

Further, the Association of Minority Health Professions Schools urges your subcommittee to maintain funding for the Minority Biomedical Research Support Grant Program at DRR. A modest rate of growth is necessary to continue this vital initiative.

In recent years, Mr. Chairman, the positive steps this Nation has taken in the last 20 years to provide a minimum amount of access to health care have begun to slow. We believe cost containment is the major culprit for this leveling off of progress.

Yet, included among the President's budget requests are several medicaid and medicare cost cutting maneuvers that will further reduce critical access to care for many poor and elderly. We urge your subcommittee to take the appropriate action to maintain health access to all Americans.

Finally, Mr. Chairman, please allow me to commend you and each member of your subcommittee for the manner in which you have carefully and compassionately supported and defended all the Federal health programs under your jurisdiction. In this time of fiscal restraint, we look to your leadership and offer our greatest measure of respect and support.

Thank you for the opportunity to present our views.

Mr. NATCHER. Thank you very much, Dr. Sullivan.

[The attachment to Dr. Sullivan's statement follows:]

AMHPS

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APPROPRIATIONS RECOMMENDATIONS FOR FISCAL YEAR 1987

Department of Health and Human Services

A. Financial Distress Grants

FY'86 Actual	FY'87 President	FY'87 AMHPS
$3.9 MILLION	-0-	$3.9 MILLION

In accordance with the Advanced Financial Distress site visit team from the Department of Health and Human Services, the Association is recommending the planned funding for the Financial Distress Grants.

B. Disadvantaged Assistance

FY'86 Actual	FY'87 President	FY'87 AMHPS
$24.4 MILLION	-0-	$28 MILLION

Disadvantaged Assistance grants and contracts are vital to the identification, recruitment, retention, and placement of minority and disadvantaged students. Institutions rely heavily upon these grants. Students also rely on these funds for support.

C. Exceptional Need Scholarships

FY'86 Actual	FY'87 President	FY'87 AMHPS
$6.7 MILLION	-0-	$7 MILLION

Exceptional need funds are allocated to health professions schools that award students with Exceptional Financial Need scholarships for their first year of post-baccalauret study.

*FY'86 Actual figure relects 4.3% Gramm-Rudman cuts

D. National Institutes of Health Research Infrastructure Development at Minority Institutions (Office of the Director)

FY'86 Actual	FY'87 President	FY'87 AMHPS
$19.2 MILLION	$10 MILLION	$25 MILLION

These grants to fund Research Centers at Minority Institutions (RCMI) and Academic Research Enhancement Awards (AREA) are critical to the development of research infrastructures, training minority professionals in research capacities, compete for research dollars, and most importantly research health problems common to blacks and other minorities.

E. Office of Minority Health

FY'86 Actual	FY'87 President	FY'87 AMHPS
-0-	-0-	$4.0 MILLION

The newly established office of Minority Health should receive line item funding through the Office of the Assistant Secretary for Health of $4 million. The Office of Minority Health will assist the Department in developing policies that will carry out the recommendations of the Secretary's Task Force on Black and Minority Health.

F. National Health Service Corps Scholarships

FY'86 Actual	FY'87 President	FY'87 AMHPS
$2.2 MILLION	-0-	$2.3 MILLION

This level of funding is necessary to assure a continuous flow of minority specialists to low income minority areas. A large number of new NHSC Scholarships are awarded to former Exceptional Need Scholarship recipients.

G. Health Professions Student Loans

FY'86 Actual	FY'87 President	FY'87 AMHPS
-0-	-0-	$5 MILLION

These new HPSL funds should be used to assist minority institutions develop and maintain a sufficient revolving fund. Many minority institutions have not had sufficient time or resources to develop revolving funds.

H. Health Education Assistance Loans

FY'86 Actual	FY'87 President	FY'87 AMHPS
$250 MILLION (no limit)	$100 MILLION	$250 MILLION (no limit)

The Association of Minority Health Professions Schools recommends that there be at least $250 million available, or no limit placed upon these loans. Even these high interest loans are necessary in light of other severe fiscal restrictions.

I. Minority Biomedical Research Support (DRR)

FY'86 Actual	FY'87 President	FY'87 AMHPS
$25 MILLION	$24 MILLION	$28 MILLION

The Minority Biomedical Research Support Grant Program supports the participation of minority undergraduates, graduates, and faculty in biomedical research at minority institutions.

DEPARTMENT OF EDUCATION

A. Guaranteed Student Loans

FY'86 Actual	FY'87 President	FY'87 AMHPS
$3.1 BILLION	$2.7 BILLION	$3.1 BILLION

The Association recommends a special provision be made to expand the limit of GSL to $50 thousand rather than $25 thousand for those students in the health professions.

B. Pell Grants

FY'86 Actual	FY'87 President	FY'87 AMHPS
$3.4 BILLION	$3.0 BILLION	$3.6 BILLION

Pell Grants provide assistance to help financially needy undergraduate students meet educational costs

C. National Direct Student Loans

FY'86 Actual	FY'87 President	FY'87 AMHPS
$208 MILLION	$163 MILLION	$215 MILLION

D. College Work Study

FY'86 Actual	FY'87 President	FY'87 AMHPS
$567 MILLION	$0 MILLION	$592 MILLION

E. Supplemental Educational Opportunity Grants

FY'86 Actual	FY'87 President	FY'87 AMHPS
$395 MILLION	$0 MILLION	$425 MILLION

* FY'86 Actual figure reflects 4.3% Gramm-Rudman cuts

Mr. **Natcher**. Mr. Conte, I yield to you.

Mr. **Conte**. It is good to see you again, Dr. Sullivan. It was a great honor for me to be part of the medical school's first commencement last year. It was a very, very moving ceremony, and it was a joy to see my good friend Lou Stokes and his whole family. We look forward to many, many years of Morehouse graduates, far into the future.

Mr. **Natcher**. Mr. Stokes?

Mr. **Conte**. And the fact that he married a constituent of mine has nothing to do with it.

Mr. **Stokes**. Mr. Chairman, I would just like to join with my colleague, Mr. Conte, and you, in your remarks to Dr. Sullivan about not only his testimony here today, but also his testimony before us on many other occasions. The organization he has testified on behalf of has given great leadership to pinpointing minority health education needs and, of course, Morehouse stands as a beacon light to all of us in the area of minority medical education.

We are very proud of that institution, the young people that graduate from Morehouse, and your outstanding leadership as the President of that organization.

Dr. **Sullivan**. Thank you very much.

Mr. **Natcher**. Thank you very much, Dr. Sullivan, you have made an excellent statement. We appreciate your appearance before the committee.

Tuesday, April 29, 1986.

HEALTH PROFESSIONS

WITNESS

DR. HENRY LEWIS, ASSISTANT DEAN, FLORIDA AGRICULTURAL AND MECHANICAL UNIVERSITY

Mr. **Natcher**. Our next witness is Dr. Henry Lewis.

Dr. Lewis, we will be pleased to hear from you at this time.

Dr. **Lewis**. Chairman Natcher, members of the subcommittee, I am Henry Lewis, Assistant Dean at the College of Pharmacy and Pharmaceutical Sciences at the Florida Agricultural and Mechanical University in Tallahassee, Florida. I appreciate the opportunity to represent the colleagues of my University and share with you and the committee some of our unique programmatic, research and professional activities in the college and university, many of which are of national importance.

I would like to share further concerns that threaten to curtail this activity, if a proper support base is not realized in the near future.

First, allow me to provide some background information relative to our health professions school and its importance nationally in terms of supplying health manpower personnel who are experts relative to medication and drug-related problems and diseases.

The pharmacy program at Florida A&M University is one of four such programs at historically black colleges and universities. For the past 10 years, Florida A&M University, has been the leading producer of black minority B.S. pharmacy practitioners.

We have produced some 16 percent of the total out of some 72 schools and colleges in the Nation. Our college has produced some 60 percent of all post-baccalaureate Doctor of Pharmacy black minority graduates.

Most recently, we became the only College of Pharmacy at the HBCUs to initiate the Ph.D. degree in the pharmaceutical sciences. Since 1975, less than 15 black males and no black females have earned the Ph.D. in this very important basic science, while better than 2,000 have been awarded to majority and other minority candidates.

Because of commitment, tradition and concern, the College of Pharmacy at FAMU will positively impact this situation in the near future. In addition to the structured programmatic contributions, our college has emphasized, for the past 10 years, strong research and professional activity of national and international significance.

We have made new and important discoveries in health care that have led to the patenting of new drugs and the development of new techniques for the better treatment of patients.

Most recently, through our South Florida affiliation, the clinical aspect of our program is serving as a national model for advising the elderly, especially the minority elderly and other medically underserved and non-compliance patients, about the prescription drugs.

This is a national health crisis and our college, due to its strong clinical component, is making a significant impact on the problem.

For the past five years, the research program has involved more than 10 percent of our 300 undergraduate students and all of our faculty and post-baccalaureate students.

The strong research activity has resulted in our college being designated a "center of excellence" by the Board of Regents of the State University System. Our college is specifically noted for its accomplishments in the area of chronophysiology and chronopharmacology.

While this work is supported by the National Aeronautics and Space Administration and the National Institutes of Health, its significance is extremely important in terms of space travel, space labs, and even transmeridian air flights while on earth.

The possibility of developing chronobiotics and compounds that can synchronize and desynchronize human subjects is being studied and advanced in our laboratories. The importance of this research ranges from an extreme interest by our national defense to similar concerns relative to athletic performance when people travel across new time zones.

The June 1, 1983 Chronicle of Higher Education wrote that, "according to Dr. Walker at the FAMU College of Pharmacy, their researchers are working to develop a new drug that will make it possible for individuals to shift their circadian cycle from one time zone to another without harm."

This research has tremendous importance in medicine, especially in terms of the proper treating of patients with drugs for illnesses with minimal toxic side-effects.

The May 27, 1978 British Medical Journal, in an editorial relative to a recent international symposium, hosted by the FAMU College of Pharmacy, wrote, "The Florida A&M Conference covered many topics from endocrinology and parasitology to neuropharmacology.

"Chronobiology is a new science and chronotherapeutics may well be a new skill for clinicians to learn as the evidence accumulates of the importance of the timing of treatment for either the day or the hour."

We have faculty presently working on a unique project which involves the microbial degradation of the fuel hydrazine. We have a group of faculty deeply involved in motion sickness research.

We are presently the only academic unit, to our knowledge, proposing to synthesize and test new drugs for motion sickness.

Syndicated columnist Carl Rowan wrote in August of 1983 that: "Scientists in FAMU's College of Pharmacy are working on the problem of trying to develop medicines to combat space sickness."

The college has established excellent research support from such agencies as NIH, NASA, ONR, AID and DOE. Total committed research dollars generated by faculty is at an all-time high of $11,800,000 through the year 1991.

The college is also involved in some special training programs. One such program is the summer Space Life Sciences Training Program, between the College of Pharmacy at FAMU and the J. F. Kennedy Space Center.

Each summer, from 1985 through 1992, FAMU will contract 30 college students nationwide to conduct research in the life sciences at NASA. This is a hands-on, six weeks program designed to increase the pool of future aerospace scientists. This is the only such program in the Nation.

Our college is one of the leading research institutions, but the quality and quantity of research and research training is seriously threatened due to the lack of adequate facilities.

In its urban development, the City of Miami two weeks ago has donated to the University for the College of Pharmacy real estate totaling approximately $4,000,000 for the purpose of constructing a research facility in their city. Funds are now needed to construct, staff and equip this laboratory.

The generous gift will allow Florida A&M University to expand its current research focus and become one of the leading research centers. In addition, the construction of this facility will allow Florida A&M University to expand its research focus to also include geriatrics and AIDS, particularly since Miami is one of the Nation's cities with the highest number of AIDS patients.

I appreciate the opportunity to appear before the committee, and I thank you for allowing me to explain our programs and our concerns relative to their continued existence.

Mr. NATCHER. Thank you, Dr. Lewis. You have made an excellent statement. We appreciate your appearance before the committee.

TUESDAY, APRIL 29, 1986.

NURSING PROGRAMS

AMERICAN ASSOCIATION OF COLLEGES OF NURSING

AMERICAN NURSES' ASSOCIATION

NATIONAL LEAGUE FOR NURSING

AMERICAN ORGANIZATION OF NURSE EXECUTIVES

WITNESSES

HON. JACK BROOKS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

LUCI BAINES JOHNSON

Mr. NATCHER. We have Mr. Jack Brooks, Chairman of the Government Operations Committee, from the great State of Texas. He is number five in seniority. When I arrived here several months after Mr. Brooks, I was 435 out of 435, and I used to go over in the House Chamber and look around and say to myself, "None of you are ever going to be defeated," and here I sit, 435th.

Mr. Brooks is now number five, and I am number seven.

Come around and have a seat with us.

Mr. BROOKS. I have a very distinguished lady, I would ask her to join me here.

Mr. NATCHER. Mr. Brooks, we will yield to you at this time.

Mr. BROOKS. Mr. Chairman, I am delighted to introduce to the subcommittee a woman who has been a familiar and delightful figure here in Washington and on the national scene for many years.

I have known Luci Baines Johnson and have watched her grow from an enthusiastic and energetic member of an illustrious family to a businesswoman and mother who has made a name for herself in her own right.

Luci has served as an executive in many aspects of her family's businesses in Texas, and as an assistant to her wonderful mother, Lady Bird. She has been active as well in social and community concerns.

It is her long-standing commitment to the field of professional nursing that brings her here today. Starting as a nursing student here in Washington at Georgetown University in 1965, Luci has maintained a deep interest in upholding and advancing the field of professional nursing.

Mr. Chairman, since her marriage to Ian Johnson Turpin in 1984, Luci has lived in Toronto, Ontario, and the Canadians' gain has been our loss. I am delighted to welcome her back to the city she called home for so many years.

Mr. NATCHER. Thank you very much, Mr. Brooks.

It is a pleasure to have you before the committee, and we will be pleased to hear from you.

Mrs. JOHNSON. The Honorable Congressman from the great State of Texas has honored me by sharing the credentials I bring to you today.

I represent the American Nurses' Association, the American Association of Colleges of Nursing, the National League for Nursing, and the American Organization of Nurse Executives, and if, aside from the record I might say, that indeed I did attend Georgetown University School of Nursing, in a very different day.

In spite of the fact that I had a 3.4 grade point average, I was no longer allowed to continue at Georgetown University School of Nursing, because those were the days of the no "M" days, as I refer to them. No M means "no marrieds, no males."

Thanks to the enthusiastic heart of this Nation, those days have changed, and we have come a long way, and I hope we will continue on an upwardly mobile course that will not only embrace marrieds and males, but embrace an increasingly diverse community in the service of nursing in the United States.

And it is on their behalf that I join you today.

Over the past 20 years, I have seen too much, heard too much, read too much to remain silent about nursing education and research. Federally-funded programs supporting nursing education and research work. They work for nurses, but they benefit everybody.

Their preventive nature reduces fiscal and moral costs. Our country has tough choices. We have limited resources and unlimited requests.

You, Mr. Chairman, and your colleagues, are in the painful position of having to choose which programs our Nation can afford.

I am here to ask you for your continued support of nursing education and research, because it happily makes economic, as well as moral sense. Good sense morally because greater education of nurses results in greater public access to greater number of people.

For example, Federal funding of advanced education in nursing has prepared nurse practitioners to work as independent care providers in HMOs, hospices, home and community settings, as well as in hospitals.

Good sense economically, because increased access and continuity of health care that highly educated nurse practitioners provide results in lower costs.

It simply costs less dollars to prevent serious illness than it does to cure them. Research in nursing has also reduced costs by providing new nursing interventions that have decreased pain and suffering and financial burdens.

But the demand continues to outstrip supply, and the needs are increasing. Prospective payment system, PPS, has created an immense demand for nurses with advanced degrees, to work in community care settings, coordinate home care for patients released from hospitals.

Recent directives to cut funding for nursing education and research have been justified on the basis of an oversupply of health care providers, and the need to cut the Federal budget deficit.

It is true, there is an oversupply within some health care professions, but it is not true for nurses with advanced degrees. In fact, several Federal studies show the exact opposite.

A serious and continuing shortage of nurses with advanced degrees in clinical specialties, administration and research. Reduced funding for advanced degrees in nursing means decreased access to health care for the aged, the indigent, the young.

To show you the importance of access to care that advanced degree nurses provide, let me focus on one area of great national need, and that is of reducing the rate of infant mortality.

Currently, the U.S. has an infant mortality rate of 11.7 deaths per 1,000 live births, which ranks us 17th in the world. A 1985 research study reveals that since 1978, the infant mortality rate has actually increased in 11 States, and instead of improving with time, the picture is worsening.

Decreased access to health services is a major factor contributing to this increase in infant mortality. In Chicago, an Adolescent Family Center staffed by nurse clinicians and nurse midwives has shown outstanding success at decreasing infant mortality rates for the patients there.

They are in the group at greatest risk for infant mortality. They are black, less than 15 years of age, poor and single. Yet, the rate of infant mortality at the center is approximately a third lower than the rate for the entire rest of the City of Chicago.

The difference, access to nursing care.

Too often, mothers of such high-risk groups give birth with no pre-natal care, because expense prohibited their access to pre-natal care.

Yet, access to catastrophic care is readily available in our neonatal units, which are unequal to many others. Doesn't it make sense both financially as well as morally to provide preventive nursing care?

Research in maternal and child health care has proven to make moral and financial sense. A team of nurses recently completed a study which identified nursing interventions to hasten the neurologic development of premature babies, allowing them to gain weight more quickly and leave the hospital four days earlier.

This is just one of countless examples of how nursing research provides practical, preventive progress for our problems. As much as I recognize our Nation's need to tighten its fiscal belt, I believe that there is evidence to justify that reducing funds for programs in nursing research and advanced nursing education is false economy.

It is being simply penny-wise and pound-foolish. This committee's support of advanced nursing education has improved access to prenatal care.

Your support of research has resulted in reducing costs and improving quality of care. I am here to request your continued support of education and research by joining us in opposition to the Administration's proposed massive cuts on both fiscal and moral grounds.

Benjamin Disraeli once said the health of the people is really the foundation upon which all of their happiness and all of their powers as a State depend, for the health of all of our people.

We respectfully ask this committee to continue to support nursing education programs, and the National Center for Nursing Research at the National Institutes of Health. Thank you.

[The statement of Mrs. Johnson follows:]

TESTIMONY

of the

AMERICAN ASSOCIATION OF COLLEGES OF NURSING

AMERICAN NURSES' ASSOCIATION

NATIONAL LEAGUE FOR NURSING

AMERICAN ORGANIZATION OF NURSE EXECUTIVES

on the

PROPOSED NURSING EDUCATION AND RESEARCH BUDGET

for

FISCAL YEAR 1987

APPROPRIATIONS COMMITTEE

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

U.S. HOUSE OF REPRESENTATIVES

presented by

LUCI BAINES JOHNSON

APRIL 29, 1986

at 11:40 A.M.

PRESENTED BY

LUCI BAINES JOHNSON, INTERESTED CITIZEN

FY 87 BUDGET REQUEST HEARING

APRIL 29, 1986

Mr. Chairman, I am Luci Baines Johnson, and I appear before you today on behalf of the American Association of Colleges of Nursing, representing 382 colleges and university schools of nursing; the American Nurses' Association, representing 188,000 nurses throughout 53 constituent state nurses' associations; the National League for Nursing, comprising 1800 institutions and 15,000 individual members; and the American Organization of Nurse Executives, representing over 2500 nursing service administrators.

I come before you today as an interested citizen who has worked for the advancement of professional nursing over a twenty year period. My committment to professional nursing began in my early days as a nursing student at Georgetown University. I continued this commitment to the advancement of nursing through service as the Chairman of the University of Texas System School of Nursing Advisory Board and as a member of the National League for Nursing Board of Review and Executive Committee. It is because of this interest in nursing that I come before you to request your support of continued funding for advanced nursing education and research.

There have been great changes in the health care system over the last few decades. One of the most profound has been the emergence of nurses with advanced degrees as independent care providers in hospitals, HMOs, hospices, and home and community care settings. As technologies for health care have become more complex, and as needs for complex care and long term care have grown in our society, the role of the nurse has become increasingly important.

Recent directives to cut funding for nursing education and research have been justified on the basis of an oversupply of health care providers, and the need to cut the federal budget deficit. It is true that an oversupply exists in some health professions. But it is not true for nursing. In fact, the opposite is the case. There is immense demand, for example, for nurses to work in community care settings to coordinate home care for patients released from hospitals. There is also a tremendous shortage of advanced nurse clinicians and nurse researchers.

In 1983, the Institute of Medicine (IOM) reported that serious and continuing shortages existed in nurses with advanced nursing degrees in clinical specialties, administration or research. In the Fourth Report to the Congress on the Status of Health Personnel, 1984, the Department of Health and Human Services projected that by the year 2000, the need for nurses with master's and doctoral degrees will be 400,000. At present only 200,000 nurses have this preparation. A 1985 Institute of Medicine Report, Personnel Needs and Training for Biomedical and Behavioral Research supports earlier findings of the Institute that a shortage of nurse researchers continues. This latest report calls for continued and increased federal support of nursing research.

As caring citizens, nurses are acutely aware of our nation's need to tighten its fiscal belt. Reduced funds for programs in nursing research and advanced education for nurses is false economy whose consequences will decrease access to health care for our aged, indigent and young. Previously, we have presented testimony regarding the importance of support for nursing education and research as this relates to gerontological health care. This year, we have chosen to focus on another area of national need, that of reducing the rate of infant mortality.

Currently, the U.S. has an infant mortality rate of 11.7 deaths per 1000 live births, ranking 17th in the world. Further, a 1985 report from the University of North Carolina cites that, since 1978, the infant mortality rate has increased among all infants in eleven states. The mortality rate for non-white infants has increased in 13 states including Maryland, Illinois, New Jersey, and North Carolina. White infant mortality rates have increased in nine states, among them New Jersey, New York, and Washington. Decreased access to health services and lack of public knowledge regarding the problem are two reasons for the worsening infant mortality picture. Those of us who are concerned for nursing and for the needs of the children of our society recognize that maternal-child health and infant mortality can be improved through access to nursing care. Advanced nurse clinicians such as nurse practitioners, nurse midwives and maternal child health clinical specialists provide cost-effective pre- and post-natal care. Therefore, it is imperative that an adequate supply of highly educated nurse clinicians and nurse researchers are available to improve access to essential pre- and post-natal care and to continue research on nursing interventions which can decrease infant mortality.

Nursing has long engaged in research and practice for the improvement of maternal-child health care. In the state of Oregon, two nurses, who are specialists in nurse midwifery and family nursing, recognized the acute need for increased pre- and post- natal care. These nurses, Mary Ann Curry and Carol Howe, worked with other nurses in the state to gather data which identified the need for improved access to maternal-child health care. They found that approximately 24% of all pregnant women in their study planned to arrive at the emergency room in labor, and that half of these would not have received any care during their pregnancy. These nurses were able to mobilize the financial resources of the state and the communities to improve access to care, especially for single pregnant women.

In Chicago, an Adolescent Family Center at Rush Presbyterian St. Lukes Medical Center, which is staffed by nurse clinicians and nurse midwives, has shown outstanding success at decreasing infant mortality rates for the patients served there. This is especially significant since the usual patient at this clinic is black, less than 15 years of age, poor and single. Such a group is at greatest risk for high infant mortality rates. Yet, the rate for infant mortality in this Chicago clinic was two-thirds the rate for the entire city of Chicago. This is an outstanding result of nursing intervention for maternal child health.

Nursing research has also been directed towards improvement of care for infants and children. One nursing research study identified nursing interventions which could hasten the neurologic development of premature infants, Infants exposed to these nursing interventions gained weight faster and left the hospital an average of four days sooner, resulting in tremendous cost savings to the health care system.

Funding for nursing education has been instrumental in providing support for the advanced nursing student, including the nurse midwife or the maternal-child health clinical specialist. For instance, the University of Connecticut, at Storrs, receives support through the professional nurse traineeship program which provides tuition and stipend help to the advanced nursing student receiving a master's degree in maternal-child health. In Kentucky, the Frontier School of Midwifery receives funding from the Advanced Nurse Education program to support faculty in the Family Nurse Midwife practitioner program. The University of Wisconsin School of Nursing also receives funding through this program for its maternal-child health and nurse midwife master's degree programs. The University of Florida School of Nursing receives advanced nurse education funding for the preparation of neonatal nurse clinicians and nurse midwives.

Decreased federal support of nursing education will have a devastating impact on the preparation of nurses with advanced degrees and result in fewer health care practitioners who are qualified to provide the highly complex care needed in today's society. Enrollments decline as these students cannot cover the cost of education on their own. Very often these students opt for part-time studies or no advanced nurse education when professional nurse traineeship support is not available. Increased numbers of part-time students also decreases curriculum continuity as predictions of student enrollment are difficult to achieve and as the student's educational experience is extended. Advanced nurse clinicians and researchers are urgently needed today. Lack of federal funding for advanced nurse education would result in fewer students obtaining advanced nursing degrees and many of those would be part-time students who would therefore be delayed in entering the work force.

In addition to support for advanced nursing education, this committee's unwavering support fostered research on interventions to improve nursing care. Many of the research grants, in fact, focus on maternal child health care. One nurse researcher at the University of Illinois is receiving support for her study of the effects of early discharge from the hospital on low income mothers. Another nurse researcher at the University of North Carolina, Chapel Hill, is studying the effects of the neonatal intensive care unit on the parent-child relationship. A University of Maryland nurse researcher is also receiving support for her study of the adolescent's ability to cope with motherhood and her mothering skills. All of these research projects help to improve the health status of children. However they are threatened by the Administration's intent to cut funding for nursing research.

Previous support by this committee for nursing education and research has been a tremendous success. Continuation of this support will assure that nurses with advanced degrees will engage in nursing practice and research to meet the health care needs of a variety of patients. The support of maternal-child health education and research which this committee has provided has already shown outstanding results. Continuation of this support is essential to meet increasing demands for access to care and to combat rising infant mortality rates.

We must again request the opposition of this committee to the Administration's proposed massive cuts in nursing education and research programs. Mr. Chairman, it is obvious that federal involvement in nursing education has been an overwhelming success and needs to be continued. We again, therefore, respectfully ask the committee to continue to support the following nursing educational programs:

1. Advanced nurse education support which provides institutional support,
2. Professional nurse traineeships which provide the graduate student with tuition and stipend support to continue advanced nursing education,
3. Nurse practitioner program support which assists the development of programs for the education of nurse practitioners who work in schools, community health clinics and midwifery clinics, and
4. Special projects which provide grants and contracts to develop innovative approaches for improving the quality and availability of nursing care, and
5. Demonstration projects which provide grants and contracts to demonstrate improved methods for expanding access to nursing practice arrangements in the community and to encourage geographic and specialty distribution of nursing personnel.

In addition, we thank the committee for its previous support of the National Center for Nursing Research at the National Institutes of Health and urge continued funding for administrative support for the Center as well as the research projects so that the Center may achieve the goals for which it was created. Mr. Chairman, we gratefully acknowledge the committee's recognition of the continued need for federal funding for nursing education and research programs. We ask for your continued support of these nursing programs at sufficient funding levels to maintain current services. Thank you.

Mr. NATCHER. Thank you very much, Mrs. Johnson. You have made an excellent statement. We appreciate your appearance before the committee. Every consideration will be given to your request.

Mr. Brooks, you can come back and see us any time you want to. Mr. Conte.

Mr. CONTE. I want to join you in welcoming Luci Baines Johnson to the committee. You did an outstanding job. This Committee has been good to nurses, and for a lot of reasons. There are several of us that have a vested interest, or conflicts of interest, really: we are married to nurses. I always use the argument when we get on the Floor of the House, and somebody tries to cut the nurses program, that you should never turn your back to a nurse.

Mrs. JOHNSON. We are aware of that, and grateful for it, and we believe the investment that you have made in nursing is an investment in the health of our Nation, and we are grateful for it.

Mr. NATCHER. Thank you very much.

TUESDAY, APRIL 29, 1986.

HEALTH PROFESSIONS

WITNESS

CLYDE B. JENSEN, PRESIDENT, WEST VIRGINIA SCHOOL OF OSTEOPATHIC MEDICINE, AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

Mr. NATCHER. Our next witness is Dr. Clyde Jensen. Come around, Dr. Jensen.

Mr. JENSEN. Mr. Chairman, members of the committee, my name is Clyde Jensen. I am the President of the West Virginia School of Osteopathic Medicine, and a member of the Board of Governors of the American Association of Colleges of Osteopathic Medicine.

My school in West Virginia is responsible for the training of osteopathic physicians to serve the underserved counties in eastern Kentucky, and also pleased to note that my school is responsible for the training of osteopathic physicians for those underserved counties in western Maryland.

Among the schools that serve as members of our American Association of Colleges of Osteopathic Medicine is a school in New England responsible for the training of osteopathic physicians for your State of Massachusetts, and our school in Ohio has the distinguished record of having about a 62 percent retention rate of its graduates in the State of Ohio.

It is a pleasure to be here today to express to you, on behalf of the American Association of Colleges of Osteopathic Medicine and its 15-member institutions, and on behalf of the 5600 osteopathic medical students nationwide, our concern for the continuation of Federal funding of Title VII grants under the Public Health Service Act, and also our concern over the continuation of Federal funding for student financial aid for medical students.

We wish to encourage the continued support of these programs. We also wish to request that the Gramm-Rudman-Hollings cuts representing the 4.3-percent reduction, if at all possible, be restored.

Osteopathic medicine is one of the most comprehensive health care careers in the United States. Our physicians are licensed in every State to perform surgery, administer psychotherapy, administer drugs, and they have special skills in the use of the musculoskeletal system in diagnosing and treating diseases.

Approximately 80 percent of our physicians are practicing primary care, and over 50 percent of them are practicing their primary care in small rural communities that might otherwise be underserved medically.

We estimate that there are 25,000 osteopathic physicians practicing in the United States today, constituting 5 percent of the American physicians manpower force, and they delivery health care to over 10 percent of the patient population.

There is an urgent need for rural physicians, the kinds of physicians that our medical schools are providing, and these would include some of the underserved areas in States like Kentucky, and in the eastern counties of that great State, and also in New England.

The osteopathic curricula is to train students in those rural areas so they will one day return there. In many cases, they come to our colleges with heavy and strong financial need, because they come from rural areas.

You have been very generous to support osteopathic medical education. We wish to encourage that continued support in recognition of the service that our graduates are rendering to the underserved communities of the United States today.

Mr. NATCHER. Thank you very much, you have made an excellent statement. We appreciate your appearance before the committee.

Mr. JENSEN. Thank you.

[The statement of Mr. Jensen follows:]

AACOM

Chicago College of Osteopathic Medicine

College of Osteopathic Medicine of the Pacific

Kirksville College of Osteopathic Medicine

Michigan State University College of Osteopathic Medicine

University of New England College of Osteopathic Medicine

University of Medicine and Dentistry of New Jersey — School of Osteopathic Medicine

New York College of Osteopathic Medicine of New York Institute of Technology

Ohio University College of Osteopathic Medicine

The Oklahoma College of Osteopathic Medicine and Surgery

Philadelphia College of Osteopathic Medicine

Southeastern College of Osteopathic Medicine

Texas College of Osteopathic Medicine

The University of Health Sciences College of Osteopathic Medicine

University of Osteopathic Medicine and Health Sciences

West Virginia School of Osteopathic Medicine

American Association of Colleges of Osteopathic Medicine · 6110 Executive Boulevard, Suite 405, Rockville, MD 20852 · (301) 468-0990

STATEMENT OF THE
AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE
TO THE
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,
AND EDUCATION AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES

PRESENTED BY

CLYDE B. JENSEN, PH.D.

APRIL 29, 1986
11:25 A.M.

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STATEMENT OF THE
AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE
to the
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES
April 29, 1986

Mr. Chairman and Members of the Subcommittee:

My name is Clyde B. Jensen. I have an earned Ph.D. and am President of the West Virginia School of Osteopathic Medicine. I'm also Secretary/Treasurer of the American Association of Colleges of Osteopathic Medicine (AACOM). I am pleased to be here today to present the views of AACOM on fiscal year 1987 funding for programs of health professions education support, including student assistance and grants to schools under Title VII of the Public Health Service Act.

Mr. Chairman, over the years osteopathic medicine has pursued a commitment to provide family and primary medical care to smaller communities throughout the country. Approximately half of the osteopathic physicians in practice today are in communities of under 50,000. About 80 percent of America's osteopathic physicians practice in one of the primary care disciplines.

My own school in West Virginia is dedicated to providing the finest family physicians for West Virginia and its Appalachian neighbors. In fact, it was created for that very purpose in 1972. The founding college in Kirksville, Missouri, has been working to meet rural health needs for more than 94 years. While each of the 15 osteopathic medical colleges is unique, they are united in their desire to produce physicians who have this orientation to family medical care. We realize that the need for primary care physicians is a national one and we are putting forth our best efforts to help meet that need.

Over the years, our colleges have been fortunate to forge partnerships with the federal and state governments, as well as with private sources, to develop programs to further our colleges' public interest missions. To date, I believe these programs have been successful in building stronger institutions, capable of training high caliber osteopathic physicians. These programs also help our colleges provide medical services to those in need in their communities.

For example, the University of Osteopathic Medicine and Health Sciences in Des Moines, Iowa, offers free medical care to unemployed people in the area. A federal family practice grant under Title VII helps support staffing in the clinics where these services are provided. Similar grants at the Chicago College of Osteopathic Medicine also help support faculty and staff to work with students and patients in their ambulatory clinics.

An Area Health Education Center grant helps the Ohio University College of Osteopathic Medicine provide medical care to rural underserved areas of southeastern Ohio. The Oklahoma College of Osteopathic Medicine and Surgery, under an AHEC grant, provides medical services to Native Americans and other minority groups in need. The Southeastern College of Osteopathic Medicine in Florida serves migrant families in that state under another AHEC grant. The Kirksville College of Osteopathic Medicine in Missouri has applied for an AHEC grant which, if approved and funded, will be used to provide medical care, stress clinics and emotional support to farm families facing economic crisis.

In each of these examples, and in others too numerous to mention, osteopathic medical students work in these settings as part of their clinical experience. Thus, they are exposed to the physician role models who encourage them to seek to practice primary care. At the same time, they are learning medicine and providing services to patients. These federal funds not only expand our ability to provide care to those who need it now, they also help us train new generations of primary care physicians to make sure we can meet medical needs in the future.

Unfortunately, the partnership our colleges have formed with the federal government is now in jeopardy. The President's fiscal year 1987 budget proposes to eliminate all funding for health professions grants and to rescind funds already appropriated by Congress in 1986. The Senate Budget Committee proposal assumes a 50 percent reduction in these funds. Were this to happen, our colleges would be hard pressed to maintain these rural medical care programs. Moreover, AACOM itself might no longer be able to operate its Health Careers Opportunity Program (HCOP) which seeks to identify students from minority and disadvantaged groups who are interested in health professions careers. This program has been in operation since 1978 and was expanded in 1982 to include a summer-study program.

Students who might not have entered a health professions career have been encouraged to do so. Since 1982, 67 percent of students in HCOP have applied to enter a health professions school.

If these funds are lost, or substantially reduced, our colleges would not have access to monies to improve their family medicine programs. Federal health professions grants have been an important source of assistance to our colleges seeking to further strengthen their primary care training. As an example, the Chicago College of Osteopathic Medicine has grants under Title VII to help strengthen predoctoral and post-doctoral programs in family medicine, thus reinforcing the College's mission to train primary care physicians. Kirksville

College has just been awarded funding for family medicine programs. At Michigan State University College of Osteopathic Medicine, these federal funds have been used to strengthen adjunct faculty involved in clinical training.

Ohio University College of Osteopathic Medicine also participates in these grants and they have produced results. Seventy four percent of their graduates in practice are practicing primary care. Sixty two percent of their graduates are providing care in Ohio, many of them in towns under 50,000 population.

I know the Administration, and some others, argue that federal support for health professionals, especially physicians, is no longer needed in light of expected surpluses. However, if that is so, why does Congress continue to express concern about shortages of primary care physicians? Why were these grant programs reauthorized last year? Why does this Subcommittee continue to recommend appropriations for these programs?

I believe the answer is clear. You and other Members of Congress recognize that needs still exist for primary care; for service to medically underserved areas; and for people in trouble. You see that these programs contribute to meeting those needs and that they should be continued.

Mr. Chairman, I am proud of the work our colleges do and I believe they have made good use of these grants in pursuit of important national health goals. But, I am also mindful of the financial constraints you here in Congress must face as you try to balance many competing demands. In view of the current budget situation, we would seek only a continuation of current funding levels, with restoration of the 4.3 percent Gramm-Rudman-Hollings cuts. Current funding is modest, but extremely helpful. It often makes the difference between beginning a new project, completing an old one or abandoning the idea.

The raw material for an educational institution is its faculty and students. The grant programs I have just discussed are used to strengthen faculty and curriculum in order for our colleges to perform their tasks of teaching and providing services more effectively. However, without the right mix of students, we would not succeed in our educational mission.

As I mentioned earlier, our West Virginia college has a special dedication to providing family physicians to our region, which I note, Mr. Chairman, includes your own state of Kentucky. Accordingly, we seek students with a special interest in providing that care in rural communities. Many of these students are from these areas themselves and mant do not have the personal or family resources to pay the costs of an osteopathic medical education. They must rely on financial assistance, much of it federal. The availability of various student assistance programs at the federal level has made it possible for our college, and other osteopathic medical colleges, to offer an education to a broad spectrum of students. Those opportunities will evaporate without a continued Federal commitment.

Let me provide you with some statistics that dramatize the dependence of our students on federal education assistance. Tuition and living expenses at a private osteopathic medical college can exceed $19,000 a year. At state schools, the average costs are just over $10,000 for residents and over $12,000 for non-residents. By the fourth year, the average costs have risen to $13,500 for residents and $15,000 for non-residents. Faced with these costs, ninety three percent of seniors in all osteopathic medical colleges expect to graduate with sizeable debts from financing their education. In 1984, that debt averaged $40,000. For students graduating in 1987, we anticipate an average indebtedness of $58,000.

This increase in debt results from two factors. First, the cost of an education continues to rise, despite efforts by our schools to hold tuition costs down. Kirksville, for example, has not significantly increased its tuition for four years and in the next academic year will reduce its tuition. The second reason for increased indebtedness results from the loss of scholarship funds, such as the National Health Service Corps Scholarships. As scholarships disappear, students shift to loan programs to finance their education. We noted a 16 percent increase in the total number of loans from 1983 to 1984.

There are a number of federal loan programs, but for our students, the most important ones have been the Guaranteed Student Loan (GSL) program, National Direct Student Loans (NDSL), the Health Education Assistance Loans (HEAL) and the Health Professions Student Loans (HPSL). I suspect that other health professions students are similarly situated. Over 86 percent of federal loans used by our students come from these sources. Both NDSL and HPSL have been reduced substantially in availability.

We are particularly concerned by the President's recommendation to reduce HEAL support to $100 million in fiscal year 1987. Fiscal year 1986 guarantees were in the range of $275 million, which is a strong indication of the need for assistance that exists. To slash those guarantees by nearly two-thirds would be devastating to our students. Approximately 50 percent of our students' loan funds come from the HEAL program. Approximately 38 percent comes from GSL. However, as we see more restrictions being placed on GSL, we see a shift to the HEAL funds. For example, in the Ohio College, the use of HEAL quadrupled from 1983 to 1985. This is occuring despite the fact that HEAL repayment can be quite a burden because of high interest rates. We are concerned over the impact that this may have on career choices our students will make. In the 1984-1985 academic year, our students borrowed over $30 million under this program. I would note here proudly that the HEAL default rate among osteopathic medical students is quite low. In fact, it is the lowest among all health professions, namely 3.61 percent.

Mr. Chairman, our colleges want to make sure that they are open to all students. To a great degree we have succeeded. Minority applications and admissions continue to rise, with enrollment increasing in 1983-1984 by 20 percent among freshmen. Women now exceed 25 percent of total enrollment. This is progress we want to continue. Over 17 percent of senior students in 1984 reported parents' incomes of less than $10,000. Fifty percent came from families with incomes below $30,000. Certainly these students could not have turned to their families for more support.

We think that part of our mission is to provide educational opportunities to students who will make good osteopathic physicians, regardless of economic or ethnic background. Those opportunities become reality only because of federal assistance to students. Frankly, there is no good substitute source of money. Our colleges are working vigorously with the states and with private sources to generate additional sources of student support, but it is still not enough to supplant a sharp reduction in federal assistance. The endowments of many of our schools are not large enough to generate adequate scholarship funds. We strongly urge that student assistance programs be maintained at current levels.

In conclusion, let me reiterate the main goal of the colleges of osteopathic medicine -- to train physicians to provide comprehensive family health services to those in need and in geographic areas of the country where the need is great. The federal government has been an important partner in that effort. We believe that the federal programs I have discussed have contributed importantly to our success thus far. However, more work remains. There is still a need for primary care physicians. There are still parts of the country with acute medical service needs. There are still students who aspire to meet these needs, but require financial help to pursue those aspirations.

We ask this Subcommittee to help us continue our work by ensuring adequate funds for programs under Title VII of the Public Health Service Act and for federal assistance programs to students.

TUESDAY, APRIL 29, 1986.

RESEARCH AND TRAINING FOR BLACK COLLEGES

WITNESSES

DR. FRANKLIN HAMILTON, NATIONAL ASSOCIATION FOR EQUAL OPPORTUNITY IN HIGHER EDUCATION

DR. VIJAYA MELNICK

Mr. NATCHER. Our next witness is Dr. Franklin Hamilton. Come around, Doctor.

Dr. FRANKLIN HAMILTON. I would like to introduce to the committee Dr. Vijaya Melnick.

Mr. NATCHER. You have been before the committee several times. Go right ahead now, Dr. Hamilton.

Dr. FRANKLIN HAMILTON. It is a pleasure to appear before you again on behalf of the National Association for Equal Opportunity in Higher Education. This is an association of some 114 historically black college and universities in this country that enroll some 25 percent of all black students in higher education and grant more than 32 percent of all baccalaureate degrees received by black students. These institutions have a long history of educating and training many of the Nation's leaders, and continue to do so even today.

We have in previous presentations spoken to the disparity between the health status of minority Americans in this country as compared to that of the majority population.

Because of this "continuing disparity in the burden of death and illness experienced by black and other minority Americans as compared to our population as a whole," the previous Secretary of HHS, the Honorable Margaret M. Heckler, established a Secretarial Task Force whose broad assignment was that of conducting a comprehensive investigation of the health problems of Blacks, Native Americans, Hispanic and Asian/Pacific Islanders.

The Task Force was developed under the chairmanship of Dr. Thomas Malone, Deputy Director of the National Institutes of Health with committee membership consisting of 18 senior scientists and Department officials.

The Task Force labored very diligently and seriously for a period of greater than one year, and delivered in August of 1985 its report, which "represented the first time the Department of Health and Human Services had consolidated minority health issues into one report."

Dr. Malone, in his letter of transmittal to Secretary Heckler, suggested that "this report should serve not only as a standard resource for Department-wide strategy but as the generating force for an accelerated national assault on the persistent health disparities which led you to establish the Task Force a little more than a year ago."

The Task Force met and carefully reviewed existing health status information for minority and non-minority populations available in the publication Health, United States 1983, and other supplemental data sources.

Upon analyzing national mortality data for more than 40 disease categories, the committee adopted a statistical approach that defines the disparity in health parameters among groups in terms of the number of excess deaths.

This technique presented the difference between the number of deaths observed in minority populations and the number of deaths which would have been expected in the minority populations had one obtained the same age and sex-specific death rate as experienced by the majority population.

In effect, this method quantified the number of deaths that would not have occurred had the mortality rate for minority groups equaled those of the majority group.

In analyzing the mortality data from 1979–1981, the Task Force identified six causes of death that, together, accounted for more than 80 percent of the mortality occurring among blacks and other minority groups in excess of that in the white population.

Those were, in alphabetical order, cancer, cardiovascular disease, strokes, chemical dependency measured by death due to cirrhosis, diabetes, homicides and accidents, and infant mortality.

The Task Force report contained several recommendations designed to address the minority health status problem. Included in those recommendations was the suggestion that the Department of Health and Human Services should adopt and foster a research agenda to investigate factors affecting minority health and should incorporate appropriate research activities on minority health into ongoing research programs consistent with the referral guidelines of each Department of Health and Human Services agency.

Five of the six causes for excessive deaths among the minority population are directly affected by the activities of the National Institutes of Health. The NIH, over the past four decades, has developed as a premier agency for the support of health-related research and research training that is performed in American universities and medical schools.

The scientific findings that accrue from NIH support have had a highly significant and measurable impact on the health of people throughout the Nation, and indeed the world.

This committee is to be commended for its long-standing support of NIH programs, for it has always recognized the need to maintain a strong and capable research effort. It is indeed the discovery of new information today that leads to an improvement of the Nation's health status in future years.

We urge this committee to keep into focus the continued need for a strong research effort as we enter these times of Gramm-Rudman-imposed reductions of the Federal deficit.

As I need not point out to members of the committee, the NIH has long recognized the need to have adequate scientific capabilities among all of this country's citizens and has developed several effective programs to accomplish this goal.

Chief among them have been the following:

One, the Minority Biomedical Research Support Program, MBRS, which, through $24,700,000 of DRR funding and an additional $10,900,000 of co-funding and interagency agreements, supports the research activities of 1,100 undergraduate students, 415 graduate students, and 778 faculty in 647 different research projects in minority institutions in this country.

Two, the Minority Access to Research Careers Program, MARC, which provides support for pre- and post-doctoral training to faculty members of minority institutions as well as support for undergraduate training of a select number of highly-talented students at minority institutions who wish to pursue research careers.

And, three, the Research Centers in Minority Institutions Program, RCMI, which is designed to significantly enhance the capacity for the conduct of biomedical and/or behavioral research at minority institutions that offer health professional and health-related science degrees. The RCMI program will assist predominantly minority health professional schools and graduate institutions in their efforts to augment and strengthen both their human and physical resources used in their research enterprise.

Each of these programs has had in the past, and I am confident will have in the future, a substantial impact on the research and training of health professionals in predominantly minority institutions.

The tangible evidence of this positive impact is contained in part in a staff report prepared by the Committee on National Needs for Biomedical and Behavioral Research Personnel, a committee of the Institute of Medicine.

The staff conducted an evaluation of the MARC Honors Undergraduate Training Program by a survey of the activities of program participants. Since initiation of the MARC undergraduate training program in 1978, some 677 trainees have graduated with bachelor degrees.

The survey for former MARC undergraduate trainees indicates that nearly half, 47.6 percent, were current students in doctoral programs or holders of doctoral degrees; another 15 percent were currently enrolled in master programs.

Overall, some three-quarters, or 76 percent, of all graduated MARC students had matriculated in a graduate or professional school. These figures, Mr. Chairman, were considerably greater than the national average in terms of the percentage of students than enter health professional careers.

Additional evidence of the impact of these targeted NIH programs is contained in other data of the staff report. These data showed that from 1976–1981, institutions with MARC and MBRS programs experienced an increase in the number of students who earned degrees in the biological sciences as compared to the national average, in which all other institutions over the same time frame experienced a decrease in the number of students who earned degrees in the biological sciences.

It is clear from reading the report that the activities of the MARC program have yielded an increase in the number of minority students that enter health professional careers.

In the face of this evidence, Mr. Chairman, it is distressing to learn that the present Administration has recommended a decrease in the amount of funds earmarked for trainees supported by NIH.

If this budgetary restriction is maintained, the very first 12 MARC honor undergraduate programs that were funded in 1977, which are in for competing renewals this year, will lose their support.

These first 12 institutions were the most competitive of all institutions that submitted applications in the first year, 1977. We strongly urge this committee to restore to the legislation sufficient funds that will allow for the continued funding of these programs.

Such a step would insure that the impact of the MARC training effort will be maintained in the immediate and distant future.

May we now turn our attention to the impact of the Research Centers in Minority Institutions program. I am sure that this committee is well aware that the announcement of the RCMI activity in the fall of 1984 to the 16 eligible institutions generated 16 applications.

All 16 applications were evaluated by the peer review process and approved for funding. Because of the limited funds available, however, only seven applications were funded in September of 1985.

Recognizing the potential value and need of RCMI activities, this committee labored to increase the funding level for the RCMI program by $5,000,000 in fiscal year 1986. As a result, we expect that an additional three to four RCMI applicant institutions will be funded within the coming months.

The potential impact of RCMI awards within the minority institutions are, and will be, significant. They will bring about an increase in the acquisition of competitive research grants, an increase in the number and the overall quality of biomedical research projects, and foster an increase in the productivity of minority Ph.D.s and minority clinical investigators.

In the long term, they will provide an opportunity for major scientific contributions that will lead to a better understanding of health problems that have major impact on the well-being of all persons, and particularly on the minority community.

Institutions that have funded programs have already initiated activities that will provide for a significant advance in the understanding of particular problems that affect the health of this country's citizens.

For example, the RCMI program at Meharry Medical College has developed an expanded research capability in the neurological sciences.

Studies of the central nervous system and the associated physiology will contribute to a better understanding of the etiology of essential hypertension and stroke. This work should contribute to an improved management of stroke victims.

At Howard University, the RCMI award will provide support for the development of an immunogenetics laboratory that will serve as a focal point for the investigation of diseases which affect all populations. Included among these are kidney disease, cancer, diabetes, hypertension, sickle cell and Acquired Immune Deficiency Syndrome.

The program at Atlanta University will allow for an expansion of a cellular and molecular biology research thrust, and provide for an increase in the acquisition of knowledge in the area of regulation and control of gene expression.

An elucidation of events that control the regulation of genes will provide for a better understanding and treatment of various genetic diseases in the human population.

These programs have been and are, Mr. Chairman, very important to both the minority community and this country as a whole. We think that the potential for success of the NIH Research Center Program Model is demonstrated, in part, by efforts of other agencies of the Federal Government to fund similar types of activities at minority institutions.

Specifically, the Department of Energy has published in the Federal Register plans for a Center of Excellence Program at Minority Institutions that will be funded with fiscal year 1986 dollars.

In addition, Dr. Erich Bloch, in his testimony before the House Appropriations Subcommittee, indicated the intention of the National Science Foundation to use $4,000,000 of its fiscal year 1987 funds to establish a Research Center Program for Minority Institutions.

In this case, Mr. Chairman, we feel that the old adage which states that "imitation is the greatest form of admiration" is quite apropos. We applaud the activities of this committee in its efforts to assist the National Institutes of Health to initiate and maintain strong and direct efforts that will impact on all the citizens of this country.

In this regard, we urge this committee to maintain the funding level of the RCMI program at $10,000,000 in the fiscal year 1987 budget.

We feel that, through activities that we have just described, we can begin to change data of the type that was released in 1983 by the National Research Council, which showed that of 4400 Ph.D. recipients in the physical sciences, only three blacks received Ph.D.s in computer sciences, nine in physics and astronomy and 16 in chemistry.

Of the 2700 Ph.D.s awarded in engineering, only 29 of those degrees were awarded to black students, and of the 5000 Ph.D.s awarded in the life sciences, only 74 of those degrees were awarded to black students. These numbers must change, and with your support, they will change.

We are confident that this subcommittee and the Congress will recognize that a strong national defense in the absence of a strong, healthy and educated populace does not provide for the longevity of a society.

Thank you, Mr. Chairman, and we will be pleased to answer any questions you may have.

Dr. Melnick?

Dr. **Melnick**. It is always a pleasure to appear before you and other committee members, Mr. Conte, Mr. Stokes. Mr. Hoyer, I was one of your old constituents.

Mr. **Hoyer**. You were one of my young constituents.

Dr. **Melnick**. I would like to quote from a statement made by Mr. Erich Bloch, Director of the National Science Foundation, in a very recent article. He said this: For 20 years, the Nation has not invested adequately in the science and engineering base, with the result we have too few young people entering science and engineering programs and inadequate facilities and equipment in the Nation's universities.

Mr. Chairman, the statement, if extrapolated to the minority institutions, is very much worse, and we have not had the kind of infusion of funds and resources that have been due to those institutions for a long time.

But with your leadership and that of those like Mr. Stokes, Mr. Hoyer, we have been able to, or have a few programs and have addressed this inadequacy, and the resources in these institutions.

The concept of the multidisciplinary center which will infuse dollars into minority and other disadvantaged institutions, is an extremely important concept, because it fosters an academic industrial cooperation which is the direction that we are moving towards in this 20th and the next centuries.

The basic research and its translation for the improvement of health status of this Nation, and particularly that of minority communities, whose health status is woefully inadequate, I think it is an extremely important concept, so that we urge the committee and you, Mr. Chairman, under your leadership, that you provide the adequate support and growth for these programs that you have so kindly provided up until this time.

Thank you very much.

Mr. NATCHER. We want to thank both of you for appearing before our committee. You have made excellent statements, and we appreciate it.

TUESDAY, APRIL 29, 1986.

PRIMATE RESEARCH CENTERS

WITNESS

DR. RONALD DUNCAN HUNT, PROFESSOR OF COMPARATIVE PATHOLOGY, HARVARD MEDICAL SCHOOL, SOUTHBOROUGH, MASSACHUSETTS

Mr. NATCHER. Our next witness is Dr. Hunt. Come around, Dr. Hunt, we will be pleased to hear from you at this time. It is a pleasure to have you back before the committee.

Dr. HUNT. It is a pleasure to be here. Mr. Conte, Mr. Stokes, Mr. Hoyer, Chairman Natcher, I would like to first thank you and the entire membership of this committee for the support and recognition that you have given to the Primate Centers Program over the past several years.

I am here representing the seven Centers based across this Nation.

Research at the Primate Centers has contributed greatly to our knowledge and understanding in the areas of cardiovascular diseases, maternal/infant relationships, diseases of the newborn, mental retardation, reproductive biology, infectious diseases, and diseases of the central nervous system.

Quoting from a document which addresses the immediate and long-range financial needs of the Primate Research Centers, prepared by the Office of the Director of the NIH, "The numerous contributions made by the Centers during the past 20 years leave little doubt of their importance to the health and well-being of mankind."

In addition to research and human health and disease, the Centers study naturally occurring diseases of primates, methods for husbandry and care, and breeding techniques to increase the supply of primates.

Indeed, research in these areas will help to prevent many species from extinction. This is the type of research for which funding is not available through categorical Institute, and for which we are dependent upon the basic support provide by this committee.

This type of research also develops many interesting new models which will contribute further to human health-related research.

I will focus on one of those shortly.

As a third role, the Centers also provide unique facilities and resources to the entire biomedical community. At my Center alone, there are presently 127 investigators from 37 institutions conducting independent or collaborative research at the Center.

These other institutions include a broad spectrum:

The Centers for Disease Control, Yale, Rockefeller University, University of California, National Institute for Alcohol Abuse and Alcoholism, Dana-Farber Cancer Institute, Massachusetts General Hospital, University of Erlangen, Germany, the Genetics Institute, Tulane and Tufts and Brown Universities.

Many of these are not immediately in New England.

Dr. Wiesel, who received a Nobel Prize for his research in vision, based at Rockefeller University in New York City, conducts his primate research at the Primate Research Center at Harvard.

The long-term needs of the Primate Center have in part been brought to this committee's attention, and through your help, modest progress has been made in maintaining and upgrading the facilities and resources for animal care and research.

We must, however, continue to address Center needs to ensure that programs of exemplary animal care are maintained, that the requirements for Public Health Service supported research can be met, and that continuing progress is made toward breeding adequate numbers of primates.

This country is in many respects in worse shape today than it was a decade ago with respect to availability of primates for research, and depreciation of the physical resources to support this research.

Demands on existing facilities exceed the available space, and the scarcity of primates leaves many government funded programs unfulfilled.

As an example, it is clear that the primate models of AIDS can significantly contribute to helping resolve the AIDS epidemic in this country. And primates will be required for the development of a safe and effective vaccine.

We are not pursuing this with the vigor that society expects, not due to a lack of scientific expertise, but because adequate facilities and number of animals are not available.

Further stressing the Primate Centers resources and their budget is the new "Guide for the Care and Use of Laboratory Animals," NIH Publication Number 85-23, revised in 1985, which promulgates new caging standards for primates. This alone has developed a center-wide need for over $1,000,000 for replacement caging.

Additionally, last year, Congress passed new legislation, Public Law 99-198, Title XVII, subtitle F, commonly known as the Improved Standards for Laboratory Animals Act, which was signed by the President on December 23, 1985.

The full impact of this legislation is yet to be determined, but without any question, it will impose a major financial burden on the Centers to provide modified housing which will simultaneously reduce our Nation's primate resources, resources which, as I have stated, are already thin.

I urge this committee to carefully review the Primate Centers' budget and make every effort to provide adequate support to meet NIH policy and the new Federal legislation. I fully realize that this is a difficult time, and that Congress is faced with many budgetary responsibilities, but the Primate Centers Program is small and can ill-afford a reduced appropriation.

Congress showed wisdom in the creation of these Centers, and the Centers in turn have lived up to their responsibilities. It is a program to which we can all look with pride.

Thank you very much, Mr. Chairman.

Mr. NATCHER. Thank you very much, Dr. Hunt, you have made an excellent statement. We appreciate your appearance before the committee.

[The statement of Dr. Hunt follows:]

Testimony presented by

RONALD DUNCAN HUNT, D.V.M.

Professor of Comparative Pathology and
Director
New England Regional Primate Research Center
Harvard Medical School
One Pine Hill Drive
Southborough, Massachusetts 01772

in favor of

PRIMATE RESEARCH CENTERS PROGRAM

Animal Resources Program Branch
Division of Research Resources
National Institutes of Health

before the

House Appropriations Subcommittee
Labor, Health and Human Services and Education

Tuesday, April 29, 1986

Mr. Chairman,

I am Dr. Ronald D. Hunt, Director of the New England Regional Primate Research Center and Professor of Comparative Pathology at The Harvard Medical School. I am here representing the seven Regional Primate Research Centers located across the Nation.

May I first take this opportunity to thank the members of this Committee for the support and recognition you have given the Primate Centers Program. Research at the Primate Centers has contributed greatly to our knowledge and understanding in the areas of cardiovascular diseases, maternal-infant relationships, diseases of the newborn, mental retardation, reproductive biology, infectious diseases, and diseases of the central nervous system. Quoting from a document which addresses the immediate and long range financial needs of the primate research centers, prepared by the Office of the Director of the N.I.H. (copy attached), "The numerous contributions made by the Centers during the past 20 years . . . leave little doubt of their importance to the health and well being of mankind." In addition to research on human health and disease, the Centers study naturally occurring diseases of primates, methods for husbandry and care, and breeding techniques to increase the supply of primates. Indeed, research in these areas will help to prevent many species from extinction.

The Centers also provide unique facilities and resources to the entire biomedical community. At my Center alone, there are presently

127 investigators from 37 institutions conducting independent or collaborative research at the Center. These other institutions include a broad spectrum: the Centers for Disease Control, Yale, Rockefeller University, University of California, National Institute for Alcohol Abuse and Alcoholism, Dana-Farber Cancer Institute, Massachusetts General Hospital, University of Erlangen (Germany), the Genetics Institute, Tulane and Tufts and Brown Universities.

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This country is in many respects in poorer shape today than it was a decade ago with respect to availability of primates for research and depreciation of the physical resources to support this research. Demands on existing facilities exceed the available space and the scarcity of primates leaves many government funded programs unfulfilled. As examples, it is clear that the primate models of AIDS can significantly contribute to helping resolve the AIDS epidemic in this country and that primates will be required for the development of a safe and effective vaccine. We are not pursuing this with the vigor that society expects, not due to a lack of scientific expertise, but because adequate facilities and number of animals are not available.

Further stressing the Primate Centers resources and their budget is the new "Guide for the Care and Use of Laboratory Animals", NIH publication No. 85-23, revised in 1985, which promulgates new caging standards for primates. This alone has developed a Center-wide need for over 1 million dollars for replacement caging.

Additionally, last year Congress passed new legislation, Public Law 99-198, title XVII, Subtitle F, commonly known as the "Improved Standards for Laboratory Animals Act" which was signed by the President on December 23, 1985. The full impact of this legislation is yet to be determined, but without any question, it will impose a major financial burden on the Centers to provide modified housing, and will simultaneously reduce our Nation's primate resources -- resources which, as I have stated, are already thin.

I urge this Committee to carefully review the Primate Centers' budget and make every effort to provide adequate support to meet N.I.H. policy and the new Federal legislation. I fully realize that this is a difficult time and that Congress is faced with many budgetary responsibilities, but the Primate Centers Program is small and can ill afford a reduced appropriation.

Congress showed wisdom in the creation of these Centers, and the Centers in turn have lived up to their responsibilities. It is a program to which we can all look with pride.

Respectfully submitted,

Ronald D. Hunt, D.V.M.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

National Institutes of Health

Division of Research Resources

REPORT ON PLAN TO ADDRESS THE IMMEDIATE AND LONG RANGE FINANCIAL NEEDS OF THE REGIONAL PRIMATE RESEARCH CENTERS

Thomas E. Malone, Ph.D.
Deputy Director, NIH

January 1986

REPORT ON PLAN TO ADDRESS THE IMMEDIATE AND LONG RANGE FINANCIAL NEEDS OF THE REGIONAL PRIMATE RESEARCH CENTERS

INTRODUCTION

In its report on the Fiscal Year 1986 budget for the Department of Health and Human Services, the House Committee on Appropriations stated:

> "The Committee is becoming increasingly concerned over the level of funding for the primate centers located throughout the country. It is imperative that these centers maintain the highest standards in the care and treatment of animals. As a result, the Committee requests the Division of Research Resources (DRR) Director to prepare a plan to address the immediate and long range financial needs of these centers. The plan should be made available to the Committee before its consideration of the 1987 budget." (House Report No. 99-289, page 76)

The following report has been prepared by the National Institutes of Health of the Department of Health and Human Services in response to this request.

BACKGROUND

The National Institutes of Health (NIH) recognized the value to biomedical and health research of establishing a durable network of primate research centers, regional and national in scope, almost three decades ago. Responding to an NIH proposal to establish seven regional primate research centers, Congress appropriated funds in 1960 and 1961 to purchase land, construct buildings, and provide for the ongoing operational support of the centers. By 1965 construction of facilities was complete and the seven centers located in Beaverton, Oregon; Covington, Louisiana; Atlanta, Georgia; Seattle, Washington; Madison, Wisconsin; Southboro, Massachusetts; and Davis, California, were operating. These same centers presently make up the Regional Primate Research Centers Program (RPRC). The mission of the RPRC Program is to provide specialized resources (physical facilities, technology, professional and technical staffing, and a variety of primate species) for research studies applicable to the solution of human health problems.

This program involves the cooperation of major academic institutions and allows the pursuit of many types of biomedical studies that require the use of nonhuman primates. The numerous contributions made by the centers during the past 20 years in the areas of reproductive biology, population control, maternal-infant relationships, disease of the newborn, mental retardation, nutrition, infectious diseases, cardiovascular diseases, diseases of the central nervous system, and behavioral sciences leave little doubt of their importance to the health and well-being of mankind. In addition to investigations of human health-related problems, the centers study naturally-occurring diseases of primates, methods for primate husbandry and care, and breeding techniques to increase the supply of primates.

The facilities and resources of the centers are available to affiliated and collaborative investigators, visiting scientists, graduate students, and postdoctoral students. The centers are also national resources for biological materials (e.g., blood, sera, tissue) and information derived from nonhuman primates that are needed by scientists working elsewhere.

CENTER ADMINISTRATION AND OPERATION

The Division of Research Resources (DRR) supports the seven centers with base operating grants. These peer-reviewed resource grants provide a stable, long-term source of support for administrative, service, and core research costs, including salaries of members of center core staff. Each center has a director and a core staff of professional and supporting personnel.

NIH base operating grants generally provide no more than half of a center's annual budget. Research grants and contracts awarded by Public Health Service (PHS) agencies to core scientists and collaborating or affiliate investigators also provide support, as does funding from other federal agencies and sponsors. Cooperative projects are also sponsored in centers by commercial and industrial organizations such as drug and pharmaceutical firms. Center host and grantee institutions have, in many cases, provided significant support on a cooperative or matching basis. A good example of such a cooperative effort is the building recently purchased by a host institution that will be renovated with special federal improvement funds to provide facilities that are needed for accreditation of the center's animal care program.

IMMEDIATE CENTER NEEDS

An extensive assessment of center needs was undertaken in 1983 as a result of increasing recognition that center physical facilities and equipment, with an aggregate value of more than $100 million, were seriously deteriorating and becoming out of date. An evaluation panel of outside experts noted the fact that the centers had been constructed in the early 1960s and that repairs, remodeling, and in some cases, expansion of physical facilities were necessary. Similar concerns were expressed about worn out and obsolete equipment, particularly inadequate caging and housing for center animals. These problems made it unlikely that each center could continue to provide optimal care and maintain accreditation by the American Association for the Accreditation of Laboratory Animal Care (AAALAC). They also seriously threatened the center program goal of becoming self-sufficient in breeding the most commonly used species. The results of this assessment showed that accomplishing needed center improvements would cost $13.5 million.

A five year program was begun in 1984 to address these needs with an earmark of $1.0 million included in report language in the 1984 appropriation bill. Additional Federal allocations totalling $2.5 million through FY 1984 and 1985 have made possible a number of improvements. These have included the replacement of leaking roofs, upgrading sewage systems, bringing utility services up to code, providing sources of emergency power, purchasing modern caging, and renovating and re-equipping animal facilities and laboratories. The substantial progress made has resulted in six of the seven centers now being accredited by AAALAC, and the expectation that the seventh one will be accredited within the next year. Unforeseen expenses have been added this year to the improvement program. The basic reference document for implementation of the Public Health Service's animal welfare policy, the "Guide for the Care and Use of Laboratory Animals" as revised in 1985, now recommends larger cages for one of the most numerous classes of macaque monkeys. Purchase of these cages and provision of the space that will be necessary to accommodate them will cost approximately $2.0 million. With the incorporation of this change, it is estimated that a total of $12.0 million will be required for completion of the program in addition to the $3.5 million that has already been allocated.

LONG TERM NEEDS OF THE PRIMATE CENTERS

Principal long term center objectives include assuring that: 1) programs of exemplary animal care are maintained, 2) there is improved accommodation to the needs of outside investigators, 3) continuing progress is made towards becoming self sufficient in producing those species needed in center programs that can be bred domestically, and 4) cooperative programs with institutions in source countries are strengthened to provide access to those species that cannot be bred in sufficient numbers domestically.

Experience has shown that center facilities and programs must be more responsive to changing circumstances and research needs if they are to fulfill their intended purpose. For example, the appearance of diseases such as acquired immunodeficiency disease (SAIDS) now makes it clear that present facilities in many cases must be improved to provide an environment that better limits transmission of this disease. Similarly realization of the great potential SAIDS offers as a model for studies of human AIDS has been slowed because of limited laboratory and containment space. Demands on facilities are also occurring because of the increasing value and scarcity of primates. Monkeys are being kept longer, used less in terminal studies, and shared more often; accordingly they are becoming older and larger. For example, the proportion of larger monkeys in the colony of one center has doubled in just four years. The scarcity of nonhuman primates and the resource intensive and long term nature of research associated with their use is also resulting in requests by an increasing number of outside investigators to use the centers. In many cases, these investigators cannot be supported because available space and other center resources are already fully committed.

Overall, the most pressing long term need is for space for additional animal holding and for breeding. Specifically, additional facilities of appropriate design are needed for 1) studies that require isolation, such as the development and testing of candidate vaccines against human AIDS, and 2) better separation and protection of valuable breeding colonies that cannot be replaced. An associated requirement is for additional space and equipment for laboratory services and studies, particularly in the areas of microbiology and immunology. Such space would provide not only better support for the work of outside investigators, but also for more extensive center colony health surveillance and pilot studies like those that led to the identification and characterization of the AIDS model.

The cost of meeting these currently identified long term needs is estimated at a total of $5 million for equipment purchases and alteration or renovation of physical facilities and $5 million for construction during the next five year period above and beyond the current modernization and improvement program. However, these requirements cannot be reasonably addressed in the absence of construction authority for the centers program.

More extensive involvement by the Primate Centers is needed in establishing conservation and resource management programs in those countries that still must be relied upon for supply of certain species of nonhuman primates needed in biomedical research and testing programs. Good examples are the South American owl monkey needed in vision and infectious disease research and the Indonesian Celebes black ape for research on diabetes. Recent severe losses in Celebes black apes from simian acquired immunodeficiency disease have left insufficient animals in the United States to assure successful breeding. Potential opportunities do exist in both South America and the South Asia regions that would help to assure the future availability of these and other species. It is estimated that an additional $1.0 million per year would be needed for at least five years to support technical cooperation and assistance in the areas named that could be helpful in assuring the supply of these and other species.

PLAN TO ADDRESS PRIMATE CENTER NEEDS

For meeting short term center needs, the highest priority for available funds is assigned to physical facility alterations and renovations and equipment purchases that have already been identified in the current five year improvement and modernization program. A primary objective is assuring that accredited center programs of animal care remain so and that the single center presently not accredited achieves and maintains that status on the most rapid timetable possible. Successful fulfillment of many of the needs in this program is possible with continued allocations of federal funds. This funding will continue to be supplemented by contributions from host institutions and other sources. To meet additional needs that may occur, such as the current new requirement to provide larger caging, the currently conceived improvement program may have to be extended beyond 1989.

For meeting longer term center needs, DRR anticipates that funding will continue on a level basis. Some tradeoffs may be required to provide the resources necessary to support expanded breeding and animal holding programs and the needs of outside scientists. Level funding will be sufficient to provide adequate core operational support and the continuing improvement program. Matching funding from host institutions or other sources would be required for any center construction project to be supported with federal funds.

DRR plans to continue to encourage the development of sources of center funding other than the base operating grant. The development of cost recovery systems offers a good example of how other sponsors, primarily the categorical institutes of NIH, will increasingly help to support the costs of center operations. The cultivation of mutually beneficial relationships between the centers and organizations in the industrial sector also will continue. These approaches will broaden the base of sponsorship for research using center resources and will allow greater flexibility for program funding to meet critical center needs.

TUESDAY, APRIL 29, 1986.

NURSING PROGRAMS

WITNESSES

PEGGY McFADDEN, NATIONAL ASSOCIATION OF PEDIATRIC NURSE ASSOCIATES AND PRACTITIONERS

MARY MURPHY

Mr. NATCHER. Our next witnesses are Ms. Peggy McFadden and Mary Murphy. Come around. Go right ahead.

Ms. MURPHY. Mr. Chairman, members of the committee, I am delighted to be here to testify before your committee this morning. This is my first time in front of your committee.

I am Mary Murphy, Registered Nurse and a pediatric nurse practitioner speaking on behalf of the National Association of Pediatric Nurse Associates and Practitioners, NAPNAP, and the Nurses' Coalition of Legislative Action, NCLA.

Attached for the record is information about NAPNAP and the Coalition. Together, with many other nursing organizations and associations, we are working to obtain full funding or $55,350,000 in fiscal year 1987 for the nursing education programs and $18,500,000 for the National Center for Nursing Research.

My testimony will address the nursing education programs. Peggy McFadden's testimony will address the nursing research programs.

Funding support for the nursing education programs and the center is essential. The Nurse Education Amendments of 1985 authorized funds for advanced nursing education. These education programs produce the nurses that practice as patient care specialists, health care administrators, nursing faculty and nurse researchers.

Only 5.6 percent of nurses meet the Institute of Medicine's recommendations for the number of specialty nurses needed to meet the health care needs of our country.

By 1990, the country will need 358,300 nurses with graduate education. If the current trend continues, there will be only 118,900 qualified nurses, less than half the demand.

The health care system has dramatically changed over the past 20 years. In the past, it was viewed primarily as the diagnosis and cure of illness. Hospitals were the major site of health care delivery, and most ambulatory care was given in physicians offices and/or hospital outpatient clinics.

Nursing practice was largely illness-oriented. Their primary work place was in hospitals, except for the public health nurses. 47 percent of all health care expenditures were financed by the patient and his or her family.

Today's health care focus is more preventive than in the past, and includes promotion, prevention and maintenance of health, as well as diagnosis and treatment of illness. Health care is increasingly delivered in the community rather than hospital settings.

Ambulatory care is increasingly offered in neighborhood health centers, free standing clinics and in specialty and multispecialty practice settings.

The lengths of stay in hospitals has decreased due to economic incentives from third-party payers. The result is a higher percentage of sick patients in our community, higher than ever recorded in our past.

Physicians comprise one of several provider groups involved in primary health care delivery. They continue as primary providers in the diagnosis and treatment of major illnesses. But, nursing practice encompasses promotion, treatment and rehabilitative services across the health illness and wellness spectrum, including direct personal care, health education, counseling and therapy.

Nursing services provided in the community have expanded to meet the complex and diversified health and illness needs of the people.

The point is that the "advanced and specialty" nurses have been, and have a continuous need to be, educated to meet the demands of our current health system.

Nurses, when properly educated and licensed, can, and do, the following: Deliver anesthesia; provide pre-natal care and deliver babies; perform physical exams, developmental assessments, order laboratory tests and health screening measures, like vision and hearing screenings; teach families about normal childhood growth and development, safety and nutrition; counsel families; assess, manage and treat acute and minor childhood and adult illnesses; manage chronic illness; and refer to other health professionals when appropriate, like physicians, and other community agencies.

The professional nurse is a recognized, essential practitioner in providing health care to our people. In the struggle to provide high quality, financially feasible, accessible health care to the young and old, sick and well, the nurse stands out as the professional, who practices effectively in every health care field.

In order to continue to provide and improve quality nursing care, combining high technology and human touch, nurses need to be educated beyond their current education.

Currently, only 5.4 percent of nurses have advanced preparation to provide direct care as clinical nurse specialists/nurse practitioners, nurse therapists, nurse midwives, nurse anesthetists or as teachers, consultants, administrators and researchers.

The nurse education programs and the nursing research center provides funds for programs to further educate nurses in these essential areas.

Federal support for nursing education and research programs has provided the Nation's citizens with advanced nursing care brought about through advanced education. It must continue. Nurses' average compensation is not high, and universities are in a funding crisis, therefore funding for advanced educational programs is crucial.

At a relatively low cost, nurses can be prepared in these areas to meet the needs of patients in the 21st century. The patient, the country, and the national budget will benefit by providing nurses, who help individuals, who promote health, who prevent illness, care for the elderly, for the sick and for the young.

We are appreciative of your support in the past, and respectfully urge that this committee recommend funding at the full authorization levels for the nursing education programs in the following amounts:

Advanced nurse training: $17,000,000; nurse practitioner and midwifery: $12,000,000; nurse anesthesia: $800,000; traineeships: $12,250,000; special projects: $9,500,000; demonstration projects: $2,700,000; faculty fellowships, $1,100,000; a total of $55,350,000.

For the National Center for Nursing Research at the National Institutes of Health, we are requesting a total of $18,500,000 be appropriated and allocated for administration, $5,500,000; nursing research grants, $10,000,000; training, $3,000,000.

As the largest group of health care professionals in the United States, nurses are and will continue to be at the forefront of our health care system. An investment now in nursing graduate education will help to ensure that nurses receive the advanced education needed to meet the needs of the ever-changing health care system.

Your favorable consideration of fully funding these programs would be appreciated. Thank you for the opportunity to appear before you. I would be pleased to answer any questions you might have.

Mr. NATCHER. Thank you, Ms. Murphy. We want to thank you for your appearance.

Ms. MCFADDEN. I am Peggy McFadden, President-elect of the American Association of Nurse Anesthetists. I am currently a certified nurse anesthetist and currently in practice at the Veterans' Administration facility in Lexington, Kentucky.

I am presenting testimony on behalf of AANA and other nursing specialty organizations about the appropriations for nurse training and nursing research.

The manpower data we show in our written testimony I am presenting for the record, and the Institute of Medicine report shows that nursing and nursing education needs continued Federal assistance in their training programs, and particular for nurse anesthetists.

Certified Registered Nurse anesthetists provide a major part of anesthesia services in this country. To be qualified to provide these services, we require for the protection of the public that they complete a continuous and rigorous program of study with certification in the specialty of anesthesia.

This cost of education is escalating for a number of reasons. Hospitals either cannot or will not physically support the educational endeavor to the extent they have in the past.

This increasing cost to the hospitals and academic centers has been cited as a major reason for the closure of our programs.

We are down in the last decade from 213 to now 106. This country is facing the extinction of nurse anesthetists, unless we can provide some financial finding from the Federal Government to support these programs.

Today, I could place over 100 nurse anesthetists right at this very moment, 13 in Kentucky, 10 in Louisville, three in Lexington. I could place 30 in Florida, in California at the Kaiser Permanente Hospital. We do need funding for these students.

Also at the same time, we are trying to move our programs into an academic framework to provide undergraduate and graduate degrees, and increase the level of our programs for 36 months, to master's levels, all for the protection of the public, and this is directly impacting on the students and their ability to pay.

These students have to have help. The nature of our programs do not lend itself to part-time study or to part-time outside work.

Some of our students do receive a stipend and some do get tuition assistance, but this money pales when it compares to residency and training. Students in the same age group, 35 to 30 years age group, the same students who have family obligations, and we believe appropriations to nurse anesthetists is important, because we have to educate our faculty.

Presently, the programs funded in the Nurse Training Act do not apply to nurse anesthesia programs, making our program essential.

I can't stress to you enough the importance of continuation of this program for the benefit of the public. So, Mr. Chairman, we are recommending, our Association is recommending that the Congress fund this program at $800,000 in fiscal year 1987. This is the same as fiscal year 1986.

It does represent a restoration of the Gramm-Rudman cuts of 4.3 percent in fiscal year 1986. Additionally, we are urging a funding level of $18,500,000 for the nurse center programs, 2,000,000 more than in fiscal year 1986.

This level of funding would enable expansion of research training by 1,000,000 and expansion of research grants by 1,000,000. Recently, the Institute of Medicine report indicated a growing need for research training support in nursing.

Like other newly developed fields, such as geriatrics, nursing should receive sufficient support for research grants to generate interest in the nursing community, in nursing research, and as just pointed out to us by Mrs. Johnson, ultimately the public will benefit.

We believe of particular importance in research is dealing with the quality aspects of nursing service and their cost-effectiveness. We believe that the Congress and the public must be informed by clinical research as to the value of nursing services, the many types of which are alternatives to other more costly services, such as anesthesia.

We urge your support for both the traineeships and the nursing center.

Mr. NATCHER. Thank you very much. You have made an excellent statement. We appreciate your appearance before the committee, and every consideration will be given to the request of you ladies. Thank you very much.

[The statement of Ms. McFadden follows:]

TESTIMONY

OF

PEGGY MCFADDEN

FOR THE

AMERICAN ASSOCIATION OF

NURSE ANESTHETISTS AND

NURSES COALITION FOR LEGISLATION

BEFORE THE

HOUSE SUBCOMMITTEE

ON

APPROPRIATIONS FOR THE DEPARTMENTS OF

HEALTH AND HUMAN SERVICES, EDUCATION

AND

LABOR

APRIL 25, 1986

Mr. Chairman:

My name is Peggy McFadden and I am President Elect of the American Association of Nurse Anesthetists. I am currently a certified nurse anesthetist and currently in practice at the Veteran's Administration facility in Lexington KY. I am presenting testimony on behalf of AANA and other nursing specialty organizations about the appropriations for nurse training and nursing research. My specific focus will be on research support for nursing and training programs for certified registered nurse anesthetists.

1. Background re: CRNA Practice

CRNA' are highly educated, licensed health professionals who have been providing a major portion of the anesthesia services in this country for about 100 years. There are more than 20,000 active practicing CRNA's providing 70 percent of the anesthesia care in rural areas and 50 percent of such services across the nation. Their practice is legally sanctioned through State laws and regulations in all 50 states and U.S. territories.

This is a profession with rigorous standards. The basic curriculum of an accredited nurse anesthesia educational program in the United States requires a minimum of twenty-four months of study and is offered at baccalaureate and masters degree levels or as a certificate-granting program. Licensed professional nurses entering these programs must have a minimum of one year of nursing experience in an acute care setting. However, the typical application has at least two years of nursing experience in an intensive care unit.

2. Justification for Continued Support

The need for continued support for nurse anesthesia education can be justified for a variety of reasons. These follow.

a. Federal Studies regarding supply and demand.

> The demand for nurse anesthesia services has been demonstrated in a variety of studies. According to a 1977 HEW study, the projected need for CRNA' ranged between 22,267 and 25,530 for 1980. Currently there are 20,000 active practicing CRNA' and this products a shortfall of from 3,312 to 6,000 compared to what was needed in 1980. With the disturbing drop in the number of nurse anesthesia education programs, we are producing a net increase of less than 500 CRNA's per year (approximately 1000 new graduates are produced each year). Since our specialty is some ninety years old, our attrition from the ranks of active practice approximates 700 per year - from retirement, death, disability or other causes.

The increasing age of the American public will also contribute to an increased demand for anesthesia providers in the coming years. The Census Bureau projects that elderly Americans will double in number between the years 1980 and 2020, and that by the year 2030 one in every five people will be at last 65 years old. The average life expectancy for those people born in 1982 is 74.5 years, according to the National Center for Health Statistics. This type of information points to an increased need for CRNA' in the future. As the average life expectancy increases, the percentage of the elderly population will also increase. It can be expected that this will result in an increase in numbers of surgical procedures as well as their complexity.

The Institute of Medicine - National Academy of Science report entitled "Nursing and Nursing Education" recommended: "The federal government should expand its support of fellowships, loans, and programs at the graduate level to assist in increasing the rate of growth in the number of nurses with master's and doctoral degrees in nursing and relevant disciplines. More such nurses are needed to fill positions in administration and management of clinical services and of health care institutions, in academic nursing (teaching, research, and practice)," Nurse anesthetists were one of the groups specifically addressed in this report.

3. Cost of Nurse Anesthesia Education

The cost of nurse anesthesia education is escalating because of a variety of reasons: (1) the inability of hospitals to fiscally support this educational endeavor to the extent it has in the past; (2) the movement of these educational programs into academic settings at the graduate level; and (3) the length of programs ranging from 24-30 calendar months. The increased cost of nurse anesthesia education had been a major reason for the decrease in nurse anesthesia education programs over the past decade by one-third, i.e from 213 to 137. Prior to the mid seventies, students often received stipends and tuition assistance from hospitals. However, with the increasing cost constraints placed on hospitals, this support has all but dried up.

4. Lack of Other Available Financing Sources

The data support the need for CRNA's as cited in our written testimony. Traineeship support is important to meet the need.

The nature of nurse anesthesia education does not lend itself to part-time study and part time work because the classroom and clinical commitment requires approximately sixty four hours per week. It is essential to complete this curriculum since certification in this specialty is required for entry into practice.

Most of the programs funded under the Nurse Training Act do not apply to nurse anesthesia educational programs, making the Nurse Anesthetist Traineeship Program essential to this nursing specialty. It is essential to simply enable the current number of students to maintain their educational programs.

In addition, the program authorizes faculty training support to enable existing faculty to upgrade their academic credentials and improve their knowledge in areas such as research and educational methods related to anesthesia. Increasing the numbers of well trained teachers will assist in maintaining our current educational programs. There has been a reduction in the number of programs recently. The Institute of Medicine report specifically recommends expanding support for the training of faculty. Faculty training support and research training support are critical for the nursing profession as a whole.

Nurse Training Support for Anesthesia Traineeship

We recommend that Congress fund Section 831 at $800,000 in FY87, the same amount as in FY86 and the amount authorized by Section 831 for FY87.

Nursing Research

The Health Research Extension Act, PL99-158, created the National Center for Nursing Research within the NIH. The Center is authorized to support basic and clinical nursing research, research training and programs in patient care research. Like NIH Institutes, the Center has an Advisory Council responsible for advising the Center on grants to be supported and on policy related to nursing research. The Center is now established and has 9 staff. A Search Committee is presently reviewing applications for the position of Director of the Center.

IN FY1986 $9.4 million was appropriated for nursing research grants and another $5 million was added, independent of that amount, to assist in establishing the center and its programs. Another $2 million has been appropriated for research training related to nursing research. These funds are all administered by the Center. The President has requested no funding for these programs.

We urge funding at the level of $18.5 million in total for the Center and training programs, $2 million more than in FY86. This level of funding would enable expansion of research training by $1 million and expansion of the research grant program by $1 million. Recently an Institute of Medicine report indicated a growing need for research training support in nursing. Applications for research training fellowships increased by 50% in FY 85 and about 30% this year. The Institute of Medicine recommends doubling the number of fellowships by 1990.

Like other newly developing fields of research such as geriatrics, this field should receive sufficient support for research grants to generate major interest in research in the nursing community. Areas of research which are funded include health promotion services and preventative care, maternal and child health and assessments of cost and productivity of clinical programs. Of particular importance is research to improve the qualitative aspects of nursing services and their cost effectiveness. We believe that Congress and the public must be informed by clinical research as to the value of nursing services and the fact that their expanded utilization would be cost effective.

Nursing research is of high quality, Mr. Chairman. For example, there are currently unfunded proposals totaling about $2 million which are approved with scores higher than those NIH is generally funding; 150 or better. We need sufficient additional funds to support such high quality research.

NURSES COALITION FOR LEGISLATIVE ACTION

Please Reply To Sender

The Nurses' Coalition for Legislative Action is a group of nursing associations dedicated to improving the health care system. The members are associated with specialty or sub-specialty nursing practice groups or work with an association concerned with a special population of patients. There are currently over 200,000 members working for the goals of the coalition.

The nursing associations are listed below:

American Academy of Nurse Practitioners
American Assembly for Men in Nursing
American Association of Neuroscience Nurses
American Association of Nurse Anesthetists
American Association of Occupational Health Nurses
American College of Nurse Midwives
American Holistic Nurses' Association
American Nephrology Nurses' Association
American Society of Ophthalmic Registered Nurses
American Urological Association, Allied
Dermatology Nurses' Association
Drug and Alcohol Nursing Association
Emergency Nurses' Association
NAACOG: The Organization for Obstetric, Gynecologic
    and Neonatal Nurse
National Association of Neonatal Nurses
National Association of Orthopaedic Nurses
National Association of Pediatric Nurse Associates
    and Practitioners
National Gerontological Nursing Association

American Association of Critical Care Nurses
American Society of Post-Anesthesia Nurses
International Association for Enterostomal Therapy
National Association of School Nurses
National Intravenous Therapy Association
Nurses Organization of the Veterans Administration
Oncology Nurses Society
Society of Gastrointestinal Assistants

TUESDAY, APRIL 29, 1986.

NIDDKD

WITNESS

ROBERT W. RITZMANN, FOR JEAN G. BACON, EXECUTIVE DIRECTOR, POLYCYSTIC KIDNEY RESEARCH FOUNDATION

Mr. NATCHER. Our next witness is Mr. Ritzmann.

Mr. RITZMANN. Thank you for this opportunity to comment on the appropriations for the National Institute of Diabetes and Digestive and Kidney Diseases for fiscal year 1987. The NIDDKD supports research on polycystic kidney disease, a heritable disorder of the kidneys leading to irreversable kidneys failure. During the last three years, the PKR Foundation and NIDDKD have been working together on increasing the awareness of and research on this disease.

I am Robert W. Ritzmann, a consulting chemical engineer from nearby Kensington, Maryland, whose three grandchildren each have a 50-percent probability of having this disease. I am presenting this statement for Jean G. Bacon, Executive Director of the Polycystic Kidney Research Foundation headquartered in Kansas City, Missouri. Because of an unexpected event yesterday, Ms. Bacon is unable to be here and asked that I convey her apologies to the subcommittee.

The PKR Foundation was founded in 1982 by Joseph H. Bruening, a retired Kansas City realtor. Mr. Bruening's family has been victimized by this little-known disease which affects about 400,000 persons in the United States. The goal of the Foundation is to promote public awareness of the disease and research into its cause and cure. In less than four years, the Foundation has assembled an international list of patients, families, friends, and health professionals to which it sends regular correspondence about the disease and research progress. A genetic roster is being developed jointly with the Indiana University School of Medicine to identify inherited disease traits and to assist in research. The Foundation has recently begun supporting small specialized research projects approved by our Board of Scientific Advisors.

A milestone in our history was the sponsorship of the First International Workshop on Problems in Diagnosis and Management of Polycystic Kidney Disease in September of 1984. Twenty-five medical researchers from the United States and Europe gathered in Kansas City to report on recent developments in the diagnosis and treatment of the disease. This was the first time many of these scientists had met to compare observations. Plans are currently underway to conduct a second such meeting.

But what is polycystic kidney disease? It is a relentless and progressive heritable disease in which cysts, fluid-filled cavities, form in the kidneys and liver, and aneurysms form in strategic blood vessels. The most common form is referred to as adult onset polycystic kidney disease, and usually manifests itself in the third of fourth decade after most afflictees have had children. While some patients live a relatively normal life and succumb to other causes, about half experience high blood pressure, severe kidney pain, bladder and kidney infections and hematuria. The rupture of a cranial or abdominal aneurysm can lead to sudden death of a seemingly healthy individual. The kidneys can grow from about four inches long to as large as a football and weigh several pounds. As the disease progresses, kidney function steadily declines, and end stage renal disease usually occurs 10 to 15 years after first clinical symptoms.

It afflicts one in every 500 to 1,000 persons. Thus, in the United States, it is about 10 times more common than sickle cell anemia, five times more common than cystic fibrosis, and more common than muscular dystrophy, hemophilia, spina bifida, Down's syndrome or Huntington's disease, all inherited diseases we readily recognize.

About 8,000 dialysis patients in the United States have reached end stage renal disease through PKD. Based on current cost projections, in 1987, medicare will spent approximately $220,000,000 treating end stage renal disease of PKD patients. With this outlay, the Federal Government has a direct economic incentive to invest in polycystic kidney disease research. Current research efforts are at an annual rate of $1,300,000, less than 0.6 percent of medicare outlays for treating the resulting end stage renal disease. Yet, encouraging progress has been made. The chromosomal location of the errant gene has recently been identified, information which has immediate clinical significance for the detection of disease carriers and designing treatments which may interdict the current inexorable progression of this disease to kidney failure.

Dr. Gary E. Striker, Director of the Division of Kidney, Urologic and Hematologic Diseases of NIDDKD, has an excellent knowledge of the disease, and we believe to be dedicated to its prevention. In December of 1983, NIDDKD embarked on an expanded research effort with the funding of a three-year research program project grant involving the University of New Mexico, University of Kansas, Indiana University and Northwestern University. In 1985, NIDDKD funded a second multiyear study through the University of Colorado Health Sciences Center. Last year, NIDDKD issued requests for proposals to study the pathogenesis of polycystic kidney disease. Several qualified studies were submitted, but it is anticipated that no more than one award will be made, because of budget restrictions.

In conclusion, with the encouraging progress that is being made in understanding PKD and advancements in the genetic sciences, it is important that the momentum gained in the last two years continue and be increased. This should not only lead to lower future costs for treating end stage renal disease but will greatly improve the quality of life for some 200,000 afflictees. We strongly endorse the research of NIDDKD in this area.

Thank you for this opportunity to brief you on the work of the PKR Foundation and encourage your continued support of the National Institute of Diabetes and Digestive and Kidney Diseases.

Mr. NATCHER. Thank you, Mr. Ritzmann. You have made an excellent statement. We appreciate your appearance before the committee.

[The information follows:]

Statement of

Ms. Jean G. Bacon
Executive Director
Polycystic Kidney Research Foundation
20 West Ninth Street
Kansas City, Missouri 64105

before
House Subcommittee on Appropriations
Subcommittee on Labor, Health and Human Services,
and Education Appropriations

Wednesday, April 23, 1986
3:45 P.M.

Good afternoon Mr. Chairman, members of the Subcommittee and other guests. I am here to encourage your support for continued appropriations to the National Institute of Diabetes, and Digestive and Kidney Disease (NIDDK) for fiscal year 1987. This Institute provides the major federal support research of polycystic kidney disease. I am Jean G. Bacon, Executive Director, representing the Polycystic Kidney Research Foundation (PKRF) headquartered in Kansas City, Missouri. During the last three years the Polycystic Kidney Research Foundation and NIDDK have been working to promote research and awareness of polycystic kidney disease.

The PKR Foundation was founded in 1982 by Joseph H. Bruening, a retired Kansas City realtor. Mr. Bruening's family has been victimized by this little-known hereditary disease that affects about 400,000 U. S. citizens. The goal of the Foundation is to promote both public awareness of the disease and research into the cause and cure of the illness. In four short years, the PKR Foundation has expanded it's efforts to include regular correspondence to an international list of 1600 patients, families, friends and health professionals. The Foundation has recently begun to support small specialized research grant projects approved by the Foundation's Scientific Advisors who collectively represent the most advanced national research technologies dedicated to the cause and cure of polycystic kidney disease. A genetic roster is also being developed jointly by the Foundation and Indiana University School of Medicine to identify inherited disease traits to assist research. A milestone in Foundation history was the sponsorship of the First International Workshop on Problems in Diagnosis and Management of Polycystic Kidney Disease in September of 1984. Twenty-five medical researchers from the United States and Europe gathered in Kansas City to report on recent developments in the treatment of the disease. Such a specialized gathering had never occurred. Plans are currently underway to conduct the second such meeting later in this decade.

In order to understand why research efforts around polycystic kidney disease should continue, it is necessary to know more about this cruel problem. Polycystic kidney disease is inherited and progressive - cysts or fluid filled cavities form in the kidney and liver, and aneurysms form in strategic blood vessels. The most common form is autosomal dominant, or adult onset polycystic kidney disease (ADPKD) and afflicts 1 in every 500-1000 persons in the United States. To further clarify, if all PKD patients were put in one place, they would equal the population of Kansas City, Missouri, slightly less than 500,000. The disease is more common than several more highly publicized hereditary illnesses. Adult PKD is usually diagnosed in a person's third or fourth decade of life, after most have had children.

Symptoms may include high blood pressure, severe kidney pain, bladder and kidney infections and hematuria. The rupture of a cranial or abdominal aneurysm can lead to sudden death of a seemingly healthy individual. The kidneys can grow as large as a football and increase their weight by several pounds. The most feared complication is kidney failure, which usually occurs ten to fifteen years after the first clinical symptoms. This relentness progression to end-stage-renal-disease accounts for 8,000 dialysis patients in the United States alone.

Based on current cost projections, as much as $220,000,000 could be spent just on end-stage-renal-disease treatment for PKD patients in 1987. Given this mammoth cost outlay, it is very important to maintained continued polycystic kidney disease research by NIDDK, the only federal resources for this research. Current research is valued at a mere $1.3 million annually. This cannot be sacrificed in light of the total federal outlay for these patients.

The PKR Foundation and NIDDK began their important collaboration three years ago. In December of 1983, the then NIADDK embarked on an expanded research effort with the funding of a three year research program project grant involving the University of New Mexico, University of Kansas, Indiana University and Northwestern University. Apart from the federal resources committed to this project, the PKR Foundation is funding a multi-year companion study at the Oregon Health Sciences University. The Foundation has also made possible Project Team meetings at selected locations around the country. In 1985, NIDDK funded a second multi-year study through the University of Colorado Health Sciences Center.

The NIH Kidney Director, Dr. Gary Striker, is an important advocate for continuation of polycystic kidney research. Last year NIDDK also issued requests for proposals to study the pathogenesis of polycystic kidney disease. Several qualified studies were submitted. Only one award is expected to be made. It is important that the momentum gained in the last two years continues. We strongly endorse continuation of the NIDDK research appropriation.

Thank you for this opportunity to brief you on the work of the PKR Foundation and to encourage your continued support of the National Institute of Diabetes, Digestive and Kidney Diseases.

April, 1986

POLYCYSTIC KIDNEY DISEASE HIGHLIGHTED AT THE ANNUAL MEETING OF THE AMERICAN SOCIETY OF NEPHROLOGY.

The major annual scientific meeting attended by several thousand kidney researchers was held in New Orleans during December, 1985. This year, PKD was featured in two important ways:

1) The exciting discovery that PKD is carried on chromosome 16 was presented in the main program by the Oxford-directed research group.

2) A two hour scientific session featured PKD, during which researchers presented new data that sparked exciting discussion. The scientific session was co-chaired by Dr. Patricia Gabow, University of Colorado,(Scientific Advisor, PKRF). Dr. Jared Grantham, University of Kansas (Scientific Advisor, PKRF) gave an invited state-of-the-art lecture entitled "Pathogentic Mechanisms in Cystic Renal Diseases". In the lecture, Dr. Grantham reviewed past and recent research that forms the basis for the current understanding of how cysts form in kidneys.

In a study coordinated by Indiana University, Dr. James McAteer, Dr. Andrew Evan (Scientific Advisor, PKRF), Dr. Jared Grantham, Dr. Frank Carone (Scientific Advisor, PKRF) and Dr. Kenneth Gardner (Scientific Advisor, PKRF) reported on studies to grow human polycystic kidney tissue cells in vitro (in test tubes and culture dishes). Many of the kidneys used to perform these studies were obtained through the PKR Foundation appeal for discarded kidneys in the May, 1985, issue of PKR Progress. These studies showed the feasibility of examining, in a very controlled environment, the abnormal growth of kidney cells from patients with PKD.

Dr. William Bennett, University of Oregon, (Scientific Advisor, PKRF) contributed two important research reports. In one report, Dr. Bennett and Dr. J. Barry found that in some patients, painful polycystic kidneys could be successfully treated by removing fluid from the cysts. In some cases, pain was relieved by removing fluid with a needle inserted through the skin in the lumbar area; more often, however, it was necessary to operate on the kidney and directly remove fluid and cyst tissue. This is a preliminary report that indicates that on the average about 75% of patients treated in this way may remain pain-free for several months. These exciting results must be extended and confirmed before physicians can recommend widespread use of the procedures. In a separate report, Doctors L. Elizinga, A. Rashad, M. Carr and Wm. Bennett showed that the usefulness of a certain antibiotic for treating infected cysts depended on how well one of the chemical components got into the cyst fluid, and whether or not the bacteria in the cyst were sensitive to the drug. Both of these studies conducted by Dr. Bennett are supported by a grant from the PKR Foundation.

Dr. Stephen Schwab, Washington University, reported on kidney infections in fourteen patients with PKD. His study revealed that women had more frequent infections than men and concluded that the kidney infections were probably acquired by entry of external bacteria into the urinary bladder, rather than through the blood stream.

Dr. Nancy Birenboim, University of Kansas, V. Donoso, R. Huseman and J. Grantham reported on the excretion of B2 microglobulin in the urine of patients with PKD. They found evidence to suggest that the non-cystic kidney tubules handled the B2 microglobulin protein in a reasonably normal way, and suggested that PKD may cause cystic changes in a relatively small percentage of the one million nephrons in each kidney.

Dr. D. Florence-Green and 5 other researchers from Henry Ford Hospital, Detroit, found an interesting association between parathyroid gland tumors and kidney stones in patients with a form of kidney cyst disease called "medullary sponge kidney."

UNIVERSITY OF COLORADO RECEIVES GRANT TO STUDY PKD

Dr. Patricia Gabow (Scientific Advisor, PKRF) and Dr. Robert Schrier have received a five year grant from the National Institutes of Health totaling over one million dollars to study the natural history and pathogenesis of PKD in patients with the disease. They will tackle some of the key issues such as the relation between the number and size of individual cysts and kidney failure; the basis of high blood pressure; the genetic basis of brain artery aneurysms; the cause of liver cysts; and genetic markers of PKD.

PKR FOUNDATION AWARDS GRANTS TO OXFORD UNIVERSITY AND UNIVERSITY OF OREGON

Significant donations from two very special persons have made it possible for the PKR Foundation to assist researchers at Oxford, University in England to continue studies on the genetic basis of PKD, and to assist researchers at the University of Oregon to find better ways to treat kidney pain and infection in patients with PKD.

POLYCYSTIC KIDNEYS NEEDED FOR RESEARCH

As announced in PKR Progress, May, 1985, several researchers in the United States need discarded polycystic kidneys for research purposes. The Foundation is coordinating the use of these discarded kidneys. We encourage patients who face the surgical removal of one or both kidneys to have their physicians contact the PKR Foundation office to be put in touch with a PKD researcher.

Jared Grantham, M.D.
Scientific Advisor

QUESTIONS AND ANSWERS

Question: There is a strong pattern of PKD in my family. At age 18 I was told (after kidney X-rays) that I did not have PKD. There is confusion in our family about who will and who will not have this disease in later life, even if an initial exam proved negative, as in my case. I am 28 years old.(J.B., Arlington, VA)

Answer: PKD has a variable age of onset but in general most patients with the adult form of PKD will show X-ray signs at age 18, even if they have no symptoms. The standard dye test (IVP) which you probably had, is the least sensitive of the tests now available. In most centers, ultrasound (Sonography) is sensitive enough to detect most cases of PKD, but not sensitive enough, in my view, to completely exclude the diagnosis. The computed tomogram (CAT scan) combined with dye infusion is the most sensitive test available. If at age 28 you have a negative sonogram and CAT scan, current data indicates you do not have PKD and will not pass it on.

Question: My mother and her brother had PKD and both had ruptured brain artery aneurysms in the 50's. I am 42. Should I have an X-ray test for brain aneurysm? (D.P., Kansas City,).

Answer: Current estimates indicate that in the absence of any symptoms the risk of a PKD patient having an aneurysm is 10-20%. As reported in the book published by the PKR Foundation, *Problems in the Diagnosis and Treatment of Polycystic Kidney Disease,* we do not know if aneurysms tend to run in families, and current studies suggest that there are no compelling reasons to screen for aneurysm all persons with PKD, whether they do or do not have a family history of aneurysm. This recommendation may change, however, as we learn more about the pattern of areurysm within families, and X-ray diagnostic screening tests are improved. Patients with PKD who note a change in symptoms involving the head region (blurred vision, dizziness, severe headache) should consult their physician.

Question: Is there a test available that one can use to determine if an unborn child has PKD? (E. S., New York)

Answer: Oxford researchers have used an alpha-globin marker to locate on chromosome 16 the gene that causes PKD. It would be possible to use the alpha-globin marker to look for the defective gene in cells grown from amniotic fluid, but the alpha-globin marker has an error rate that is not yet optimal for in-utero diagnosis. As researchers find markers closer to the gene than alpha-globin it will be possible to do ante-natal testing for those who desire it.

NEWS FLASH

The Foundation has been recently contacted by the National Institute of Diabetes and Digestive and Kidney Disease (NIDDK), one of the National Institutes of Health (NIH). NIDDK is soliciting volunteers for a MULTICENTER STUDY OF NUTRITIONAL THERAPY IN PROGRESSIVE KIDNEY DISEASE. If you are between the ages of 18 and 75, within commuting distance of one of the eight centers* and have renal function as measured by creatinine levels from 1.4 to 10 mg./dl. for males and 1.2 to 10 mg./dl. for females, please contact Ms. Jennifer Gassmann at 1-216-444-2980, Data Coordinator for further details.

*Boston; Torrance, California; Los Angeles; Iowa City, Iowa; Nashville; and Baltimore.

Diet Information for "Kidney" Patients

In response to numerous requests, the scientific advisors of PKR Foundation are organizing a booklet of diet information that will be useful for patients with kidney disorders, including PKD. The booklet should be available, for a small fee, from the PKR Foundation office this summer.

WE'VE CHANGED OUR ADDRESS:

To give better access to our correspondents, we've moved to new quarters.

Polycystic Kidney Research Foundation
20 West 9th Street - Suite 250
Kansas City, MO 64105
Telephone: (816) 421-1869

October,1985

NOW WE CAN TELL!

Have you ever been told some exciting news only to be instructed that you couldn't whisper the secret to another soul? That is exactly how those of us at the PKR Foundation office have felt since August, 1985, when Dr. Michael Conneally of Indiana Univeristy "whispered " to us that Oxford University researchers had discovered the location of the defective PKD gene in humans. We could not "tell" because the manuscript describing the research was not to be published until the second week of October, and premature disclosure is considered improper in scientific circles.

On October 8, 1985 in a lecture at the University of Kansas School of Medicine sponsored by the PKR Foundaiton, Dr. Stephen Reeders, the leader of the Oxford research team, publicly announced for the first time that the gene had been located on chromosome 16. Dr. Reeders' discovery was subsequently reported by the Associated Press on October 10, 1985 (see reprint). On October 11, The Kansas City Star announced the same findings (see reprint).

This is a profoundly important discovery that will advance our studies into the cause and cure of PKD. Dr. Reeders has kindly written the following article for the newsletter that gives more background to his study.

Jared J. Grantham, M.D.
Chairman, Scientific Advisors

Summary of Genetic Research
Dr. Stephen T. Reeders
University of Oxford

Adult polycystic kidney disease is one of the commonest serious inherited diseases such as muscular dystrophy, cystic fibrosis, and Huntington's disease. Patients who suffer from polycystic disease develop cysts in their kidneys which grow progressivley larger during their lives. These cysts usually begin to make their presence felt when the sufferer reaches the age of about thirty, with high blood pressure, blood in the urine, urinary infection, and pain in the loins. In the next two decades of life the cysts cause increasing damage to the kidneys such that permanent dialysis or transplantation often become necessary. Although medical treatment can do much to preserve the function of the patient's kidneys for as long as possible, no specific treatment is available to prevent the kidney failure which the dysts cause.

The cause of the disease is an abnormality in the genetic code for the gene which is responsible for normal development of the kidneys. Each of us carries two copies of this gene, one inherited from our mother and one from our father. When one of these containes an error (called a mutation) normal development of the kidneys does not occur, and, for some unexplained reason, cysts develope in the kidneys. If the

PKR Progress

Polycystic Kidney Research Foundation is the first organization devoted to research leading to a cure for polycystic kidney disease—a relentless killer. PKR Progress is our Foundation newsletter for patients, physicians and research scientists

May, 1985

New Developments in Polycystic Kidney Research. The PKR Foundation has received word from the National Institutes of Health that a program announcement will be issued to solicit research projects on dominantly inherited polycystic kidney disease. Researchers are specifically encouraged to develop cell banks (collections of blood lymphocytes) from the largest known polycystic disease families, so that these cells can be made available to the research community. NIH is encouraging studies to discover the primary defect and location of the affected gene that causes PKD by using sophisticated new molecular analysis. The foundation's Roster Project is designed to locate polycystic families, so we are asking all PKD patients to return their "Family History" data form to Indiana ~~Univer~~sity. If you do not have a data form, please contact the PKR Foundation Office.

This is the first time that NIH has specifically requested research applications directed at polycystic kidney disease. The PKR Foundation has played a significant role in bringing the increased awareness to NIH of the need for PKD research, and we are extremely pleased with these new developments.

PKR Foundation Annual Meeting. The officers, board members, staff, and scientific advisors of the PKR Foundation will gather July 20-21, 1985 in Kansas City for the Annual Meeting. A quarterly review for PKD researchers will be held in conjunction with the meeting.

Polycystic Kidneys Needed for Research. From time to time it is necessary for a patient with polycystic kidney disease to have one or both kidneys removed. There are several researchers in the United States who are using these discarded kidneys to try to determine the cause and potential cure of polycystic kidney disease. The PKR Foundation is helping to coordinate the utilization of these precious discarded kidneys. We encourage individuals who are going to have one or both kidneys removed to contact the PKR Office, so you can be put in touch with a researcher. It is important to have several days to prepare for this, so please keep this in mind should you decide to donate your kidneys for research.

Volunteers Needed. To promote awareness of PKD and the work of the PKR Foundation, Mr. Joseph H. Bruening, President of the PKR Foundation, has inaugurated a volunteer program. Dialysis centers are located all over the country, and volunteers are asked to visit these centers and call on the medical director and staff. If you enjoy meeting people and working toward the cure of PKD, please contact Elcie Custer in the PKR Office.

New Book Published Soon. The proceedings from the First International Workshop on PKD, "Problems in Diagnosis and Management of Polycystic Kidney Disease", will be published this summer. The price of the book is $14.95 plus $2.00 for mailing. If you would like a copy, send your name and address with a check to the PKR Foundation.

(please turn the page)

PKR Foundation *127 West Tenth Street*
Kansas City Missouri USA 816 421 1869

Questions & Answers from Dr. Grantham. We have received many questions on PKD from people all over the country. Beginning with this issue, Dr. Jared Grantham, who chairs the PKR panel of scientific advisors, will answer some of these questions in our newsletter.

QUESTION: My husband and three daughters have PKD. Our daughters have had problems with pain in the side and the back. My husband has been in the hospital twice for cysts breaking and bleeding with severe pain. Could you please explain these symptoms and tell us, "Where does this all lead?" S.S. (Elberton, Georgia)

ANSWER: Abdominal pain is the most common symptom associated with PKD. Most of the time it is not possible to tell for sure what causes the pain. Young persons sometimes feel a heaviness in the flanks and abdomen that may simply be related to the large size of the kidneys. The enlarged kidneys are rather susceptible to minor injuries. A bump in the side can occasionally cause bleeding into the substance of the kidney, or the blood can find its way into the urinary tract and show up in the urine. The first time this happens, it can be a very frightening thing, but most patients with PKD learn that the bleeding is a self-limited process and that "they can live with it". Of course, it is a good idea to notify your physician anytime you have blood in the urine. Infections of the kidneys can also cause pain, but this is usually associated with fever and chills and pus in the urine. PKD patients have a higher incidence of kidney stones than other persons, and persistent pain may be the first sign of a kidney stone. Very rarely, older patients with PKD have been found to have kidney tumors.

Fortunately, some patients with PKD never have significant pain or any of the complications noted above. But, for those who have pain, it is important to check with the doctor about the kind of medication that can be used to control the pain. Most doctors advise patients with kidney disorders to avoid aspirin and some of the newer pain remedies that are sold over the counter. Some of these chemicals may have bad effects on the kidneys and can aggravate kidney bleeding. For most patients the pain is annoying but not disabling. As a rule-of-thumb, the less medication one takes for pain, the better.

As far as we know, pain and bleeding are not associated with a bad prognosis in respect to the function of the kidneys. Only rarely are operations necessary to relieve obstructions in the urinary tract that cause pain and bleeding.

QUESTION: Is PKD a female related disease? J.K. (Omaha, Nebraska).

ANSWER: This question indicates some of the confused information patients have received about the hereditary pattern of polycystic kidney disease. PKD affects men and women equally and is passed from men and women to their children equally. If you have PKD, each of your children has a 50-50 chance of inheriting the defective gene and developing PKD.

TUESDAY, APRIL 29, 1986.

EMPLOYMENT AND TRAINING PROGRAMS

WITNESS

JAMES P. DANIELS, COMMISSIONER, DEPARTMENT OF EMPLOYMENT SERVICE, KENTUCKY CABINET FOR HUMAN RESOURCES, NATIONAL GOVERNORS' ASSOCIATION

Mr. NATCHER. Our next witness is Mr. James P. Daniels. We are glad to have you before the committee, you and these other people here with you.

Mr. DANIELS. I am James Daniels, Commissioner of the Kentucky Department for Employment Service, Kentucky Cabinet for Human Resources, and today, I am testifying on behalf of the National Governors' Association on the Labor, Health and Human Services, and Education appropriation for fiscal year 1987.

Specifically, my testimony will provide the States' perspective on why sustained Federal financial support for employment and training programs—in this case, the Job Training Partnership Act and WIN—is important for the continued evolvement of a strong public/private partnership to strengthen our Nation's economy.

Let me begin by saying that the Governors recognize the critical importance of reducing the Federal deficit and they have publicly supported a variety of proposals to assure a balanced package of spending and revenue changes.

They agree that Federal aid to State and local government cannot be exempt from consideration. However, they are opposed to large shifts in current Federal responsibilities to State government, based on the misconception that States have fiscal surpluses.

Clearly, the current fiscal condition of the States does not provide a bright picture. Already, at least 17 States have been forced to cut their current year's budget to avoid impending deficits.

The NGA policy position on the budget calls for freezing 1987 appropriations at the 1986 level for non-defense discretionary spending. The Governors feel strongly that the burden of budget cuts not fall on already hard-pressed lower-income Americans, and that special consideration to given to "investment" programs such as job training and education which enhance the productivity of this country.

The Job Training Partnership Act is unique among Federal legislation in that it has created a viable and potentially very significant three-way partnership between the Federal Government, the States and the private sector for the design, delivery and management of training, employment and related educational services in the country.

Consistent with the principles of federalism, JTPA has assigned shared responsibilities for carrying out the intent of the Act to the Federal Government and the States.

The Act has provided States with welcome policy latitude to mesh JTPA goals with State priorities related to economic development, educational and welfare reform. Some 15 States now have State-appropriated programs dealing with various aspects of worker adjustment that are being effectively coordinated with JTPA Title III activities.

Other States are combining JTPA and other resources to address youth unemployment and other critical State and local concerns. JTPA has also provided States with useful management tools in the form of the performance standards system and State planning, technical assistance and oversight functions to promote both the efficiency and effectiveness of the services provided.

At the local level, JTPA has created a hospitable environment for private sector involvement in the policymaking process. Throughout the country, private sector volunteers have responded to this real invitation with a sustained and high-level commitment of time and effort.

The Private Industry Councils, PICs, created through the Act, have shown the potential of becoming the much-needed convening body to effect desired coordination within JTPA and between JTPA and related systems.

I believe it is fair to say that the Act has successfully achieved a good balance between emphasis on fiscal and programmatic accountability, the principles of partnership, and the need for local diversity through decentralized decisionmaking.

These important structural developments within the States facilitated to a significant extent by JTPA, make JTPA more important within the Federal intergovernmental system than its past or current funding level would suggest.

States and localities have used available JTPA resources to leverage State and local resources and make mainstream education and other delivery systems more responsive to the needs of at-risk individuals, such as those eligible for participation in JTPA.

Strategic use of limited resources to accomplish these broader institutional change goals, while at the same time serving the immediate needs of clients, is not easy. It requires careful planning and patience.

An important initiative undertaken by the Kentucky Department of Employment Services and the Kentucky Department of Education is designed to coordinate and expand the SDA programs for JTPA-eligible in-school youth through the State Education Grant.

These programs allow the local education agencies to expand their dropout prevention programs and provide a coordinated approach for employment and training. Once these youth obtain their high school diploma and want to enter the labor market, but lack job-specific skills, they may be enrolled into an SDA occupational training component.

In Kentucky, dropouts over the age of 18 numbered 1,113,469 in the 1980 Census. In an effort to provide literacy training for these individuals, we have supplemented the Department of Education's adult educational programs through the JTPA educational grant.

Both the dropout prevention and the adult literacy programs are matched one to one, with JTPA and educational funds.

Nearly 8 percent of all Kentucky JTPA participants are handicapped, and in order to encourage employment and training services to this population, Kentucky early on provided incentives to the SDAs who developed model programs for handicapped.

We believe our State and local initiatives to use JTPA as a focal point for change will be enhanced by our Federal partner's policy and other support for such activities.

As the "managing partners" in the JTPA system, we feel that we need to raise several funding-related concerns with the subcommittee.

Even without the President's proposed budget cuts and the budget reductions resulting from Gramm-Rudman-Hollings, the real value of the Federal investment in employment and training is being eroded by inflation.

The JTPA system, which by all accounts is successfully working in communities throughout the country, could not be sustained with its present delivery system of approximately 600 special delivery areas and Private Industry Councils if any additional reductions were to be made.

Furthermore, despite the potential of JTPA as an organizing force within States, it is important to recognize that even at PY 1985 funding levels, there were only sufficient resources in Title II-A, for instance, to serve between 3 and 4 percent of the eligible population.

This means that it is unreasonable to expect JTPA Title II-A to absorb proposed cuts in such programs as Job Corps, WIN and the Summer Youth Employment Program authorized under Title II-B without causing a reduction in service to other groups now being served.

The Title III Dislocated Worker program has become an integral part of every State's strategy for addressing worker dislocations which continue to occur throughout the country in large urban areas, on farms, and in many different kinds of communities in between.

Substantial funding cuts imposed on the program last year will absorb funds unexpended as a result of slow initial program start-up and in those States that have expended high proportions of their allocations, will result in sharp decreases in the level of services provided. For the most part, States are not in a position to absorb these cuts with increased State funding.

We are concerned that the Department of Labor's proposal to allocate all Title III resources available in PY 1987 on a discretionary basis from the national level will seriously undermine the States' ability to plan for and institutionalize worker adjustment strategies.

It is difficult to argue with the State objective of targeting limited resources on those areas and industries in particular need, but there is little or no evidence that a Federal system could or would target resources more efficiently, especially without a Federal plant closing notification system.

Should resources be distributed as proposed, inequities no doubt would occur, exacerbating existing problems. We believe that the needs of our Nation's dislocated workers can be better served by maintaining the authorizing committees' legislated 75-25 percent split between resources allocated to States by formula and discretionary resources retained at the Federal level.

The absence of a formula allocation would prevent States from moving ahead with further development of early warning systems and institutionalization of flexible and timely response mechanisms.

In addition, the shift to discretionary funding only would slow the response time of States during the critical early weeks of a layoff situation, and therefore, reduce the effectiveness of the program.

We are distressed at the substantial cuts proposed in the Summer Youth Employment Program, SYEP, especially in light of the continuing alarming statistics on youth unemployment and educational deficiencies.

The recommendation for reduced SYEP funding seems glaringly inconsistent with the Administration's new emphasis on addressing illiteracy. We are concerned, too, with the Department of Labor's proposal to target all calendar 1988 Summer Youth Employment Program funds to the largest cities with the highest concentration of unemployed youth.

Although we recognize the need to find better ways of addressing the youth employment problem in areas with high concentration of need, we do not believe that vast areas of the country with substantial needs of their own should be left without SYEP resources.

This program is an important community resource for combatting priority literacy and dropout problems, and therefore needs to be made available throughout the Nation.

Kentucky has sought to upgrade the type of training provided by the Title II-B summer program. In the 1985 program, a remedial education component was initiated in five of the nine SDAs using State education grants.

In 1986, six of the SDAs have included this component using their own II-B funds, and we believe that that number will increase in the future.

Lastly, two of the most important aspects of JTPA, at least from the point of view of their value for management improvement, are the provisions for forward funding and a two-year planning cycle.

Against the backdrop of monumental problems under CETA, both of these provisions were greeted with much anticipation by the private sector volunteers and the professionals involved in the management of the program, because they would make implementation of longer-term strategies possible.

Unfortunately, since the passage of JTPA in 1982, annual budget uncertainties have made two-year planning a virtual impossibility. We urge you to provide as much funding stability as possible in terms of prospective funding and by permitting the system to spend already allocated dollars within the authorized time periods.

While the Governors support the Job Training Partnership Act which serves the economically disadvantaged, they also support continued funding fore the WIN and WIN demonstration programs as they target the AFDC recipient.

We feel this program in Kentucky has been successful in increasing the self-sufficiency of AFDC recipients by returning them to the labor force as productive workers.

For the period of October 1, 1978 through September 30, 1985, Kentucky has had the following accomplishments:

Registered: 132,592; entered employment: 20,339; retention rate: 86 percent; placed in training: 20,452; welfare savings: $31,068,826; WIN budget expense: $18,295,178.

As you surely are aware, the Committees on Ways and Means and Education and Labor, as well as the Democratic Caucus are seriously reviewing this Nation's work and welfare system.

It is critical, therefore, that the Federal Government maintain its support for these types of programs while such a review is being undertaken.

Our challenge today is to create a flexible job training and employment system that can meet the needs of very diverse unemployed citizens residing within our States. Just as the problems faced within our State and local economies extend beyond the boundaries of any one State, the States' ability to prepare our Nation's work force for continued economic growth is inextricably tied to and requires a sustained and substantial commitment from the Federal Government.

While it is impossible to ignore the need for restraint in Federal funding, we urge you to carefully consider support for employment and training programs.

Thank you for providing me the opportunity to present the Governors' views on fiscal year 1987 appropriations for employment and training programs. I will be happy to answer any questions you may have.

Mr. NATCHER. Thank you very much, Mr. Daniels. You have made an excellent statement. We appreciate your appearance before the committee. Thank you very much.

[The statement of Mr. Daniels follows:]

National Governors' Association

Lamar Alexander
Governor of Tennessee
Chairman

Raymond C. Scheppach
Executive Director

STATEMENT OF

JAMES P. DANIELS

COMMISSIONER

DEPARTMENT FOR EMPLOYMENT SERVICES

CABINET FOR HUMAN RESOURCES

COMMONWEALTH OF KENTUCKY

on behalf of

THE NATIONAL GOVERNORS' ASSOCIATION

before the

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,
EDUCATION AND RELATED AGENCIES APPROPRIATIONS
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES

on

FUNDING FOR EMPLOYMENT AND TRAINING PROGRAMS

11:55 a.m., April 29, 1986

HALL OF THE STATES · 444 North Capitol Street · Washington, D.C. 20001-1572 · (202) 624-5300

INTRODUCTION

Good morning. My name is James P. Daniels. I am Commissioner of the Department for Employment Services of the Cabinet for Human Resources in the Commonwealth of Kentucky. This morning I am pleased to testify on behalf of the National Governors' Association on the Labor, Health and Human Services, and Education appropriation for Fiscal Year 1987. Specifically, my testimony will provide the states' perspective on why sustained federal financial support for employment and training programs -- in this case, the Job Training Partnership Act and WIN -- is important for the continued evolvement of a strong public/private partnership to strengthen our nation's economy.

GOVERNORS' POSITION ON THE BUDGET

Let me begin by saying that the Governors recognize the critical importance of reducing the federal deficit and they have publicly supported a variety of proposals to assure a balanced package of spending and revenue changes. They agree that federal aid to state and local government cannot be exempt from consideration. However, they are opposed to large shifts in current federal responsibilities to state government based on the misconception that states have fiscal surpluses. Clearly, the current fiscal condition of the states does not provide a bright picture. Already, at least 17 states have been forced to cut their current year's budget to avert impending deficits.

The NGA policy position on the budget calls for freezing 1987 appropriations at the 1986 level for non-defense discretionary spending. The Governors feel strongly that the burden of budget cuts not fall on already hard pressed lower income Americans and that special consideration be given to "investment" programs such as job training and education which enhance the productivity of this country.

THE JOB TRAINING PARTNERSHIP ACT

The Job Training Partnership Act (JTPA) is unique among federal legislation in that it has created a viable, and potentially very significant three-way partnership between the federal government, the states and the private sector for the design, delivery and management of training, employment and related educational services in the country. Consistent with the principles of federalism, JTPA has assigned shared responsibilities for carrying out the intent of the Act to the federal government and the states.

The Act has provided states with welcome policy latitude to mesh JTPA goals with state priorities related to economic development, educational and welfare reform. Some 15 states now have state appropriated programs dealing with various aspects of worker adjustment that are being effectively coordinated with JTPA Title III activities.

Other states are combining JTPA and other resources to address youth unemployment and other critical state and local concerns. JTPA has also provided states with useful management tools in the form of the performance standards system and state planning, technical assistance and oversight functions to promote both the efficiency and effectiveness of the services provided.

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These important structural developments within the states facilitated to a significant extent by JTPA, make JTPA more important within the federal intergovernmental system than its past or current funding level would suggest. States and localities have used available JTPA resources to leverage state and local resources and make mainstream education and other delivery systems more responsive to the needs of at-risk individuals such as those eligible for participation in JTPA. Strategic use of limited resources to accomplish these broader institutional change goals, while at the same time serving the immediate needs of clients, is not easy. It requires careful planning and patience.

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As the "managing partners" in the JTPA system, we feel that we need to raise several funding-related concerns with the Subcommittee.

OVERALL JTPA FUNDING LEVEL

Even without the President's proposed budget cuts and the budget reductions resulting from Gramm-Rudman-Hollings, the real value of the federal investment in employment and training is being eroded by inflation. The JTPA system, which by all accounts is successfully working in communities throughout the country, could not be sustained with its present delivery system of approximately 600 Service Delivery Areas and Private Industry Councils if any additional reductions were to be made.

Furthermore, despite the potential of JTPA as an organizing force within states, it is important to recognize that even at PY 1985 funding levels, there were only sufficient resources in Title II-A, for instance, to serve between three and four percent of the eligible population. This means that it is unreasonable to expect JTPA Title II-A to absorb proposed cuts in such programs as Job Corps, WIN and the Summer Youth Employment Program (SYEP) authorized under Title II-B without causing a reduction in service to other groups now being served.

TITLE III

The Title III Dislocated Worker program has become an integral part of every state's strategy for addressing worker dislocations which continue to occur throughout the country in large urban areas, on farms, and in many different kinds of communities in between. Substantial funding cuts imposed on the program last year will absorb funds unexpended as a result of slow initial program start-up and in those states that have expended high proportions of their allocations, will result in sharp decreases in the level of services provided. For the most part, states are not in a position to absorb these cuts with increased state funding.

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We are distressed at the substantial cuts proposed in the Summer Youth Employment Program (SYEP) especially in light of the continuing alarming statistics on youth unemployment and educational deficiencies. The recommendation for reduced SYEP funding seems glaringly inconsistent with the Administration's new emphasis on addressing illiteracy. We are concerned, too, with the Department of Labor's proposal to target all Calendar 1988 Summer Youth Employment Program funds to the largest cities with the highest concentration of unemployed youth. Although we recognize the need to find better ways of addressing the youth employment problem in areas with high concentration of need, we do not believe that vast areas of the country with substantial needs of their own should be left without SYEP resources. This program is an important community resource for combatting priority literacy and dropout problems and therefore needs to be made available throughout the nation.

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TWO YEAR PLANNING

Lastly, two of the most important aspects of JTPA, at least from the point of view of their value for management improvement, are the provisions for forward funding and a two-year planning cycle. Against the backdrop of monumental problems under CETA, both of these provisions were greeted with much anticipation by the private sector volunteers and the professionals involved in the management of the program because they would make implementation of longer-term strategies possible. Unfortunately, since the passage of JTPA in 1982, annual budget uncertainties have made two-year planning a virtual impossibility. We urge you to provide as much funding stability as possible in terms of prospective funding and by permitting the system to spend already allocated dollars within the authorized time periods.

WORK INCENTIVE (WIN) PROGRAM

While the Governors support the Job Training Partnership Act which serves the economically disadvantaged, they also support continued funding for the WIN and WIN demonstration programs as they target the AFDC recipient. We feel this program in Kentucky has been successful in increasing the self-sufficiency of AFDC recipients by returning them to the labor force as productive workers. For the period of October 1, 1978 through September 30, 1985 Kentucky has had the following accomplishments:

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As you surely are aware, the Committees on Ways and Means and Education and Labor as well as the Democratic Caucus are seriously reviewing this nation's work and welfare system. It is critical, therefore, that the federal government maintain its support for these types of programs while such a review is being undertaken.

CONCLUSION

Our challenge today is to create a flexible job training and employment system that can meet the needs of very diverse unemployed citizens residing within our states. Just as the problems faced within our state and local economies extend beyond the boundaries of any one state, the states' ability to prepare our nation's workforce for continued economic growth is inextricably tied to and requires a sustained and substantial commitment from the federal government. While it is impossible to ignore the need for restraint in federal funding, we urge you to carefully consider support for employment and training programs.

Thank you for providing me the opportunity to present the Governors' views on FY 1987 appropriations for employment and training programs. I will be happy to answer any questions you may have.

Mr. NATCHER. The committee will now recess until 2:00 this afternoon.

AFTERNOON SESSION

TUESDAY, APRIL 29, 1986.

NIDDKD

WITNESS

DR. DARRACOTT VAUGHAN, CHAIRMAN, RESEARCH COMMITTEE, AMERICAN UROLOGICAL ASSOCIATION

Mr. NATCHER. Our first witness this afternoon is Dr. Vaughan. Come around, Dr. Vaughan.

Doctor, we will be pleased to hear from you at this time.

Dr. VAUGHAN. Chairman Natcher, it is my pleasure to be back again this year before this committee. I will be brief because I know it is a long day and you are already a touch behind.

I would first like to thank you for a number of areas for the urological community that you have supported in the past, and I would like to express my thanks to the committee. I am speaking on behalf of the American Urological Association, which represents 6,000 or so urologists across the country, but actually I am representing the patients that we take care of, that is the majority of the males over 60 that are afflicted with benign prostatic hypertrophy, the elderly with incontinence and bladder disease, the women with urinary tract infection and children with congenital anomalies.

It has been an exciting year for research. Time precludes my discussing these many advances, and I would like to move on to some specific areas of direct concern.

As you know, in the House Report 99-289, your committee requested an evaluation of the proposal to establish six centers for kidney and urologic research. This has been done by the National Institute of Health, NIDDKD, and that report indicated that the major goal of the center project should be directed to the prevention of end-stage renal disease and directed to benign prostatic hypertrophy.

I think the committee also should be aware that end-stage renal disease and hypertrophy have a cost of approximately $4 billion per year to the population of the United States.

Also, I think you are well aware that the direction of care for benign prostatic hypertrophy is simply intervention with operative procedures, and we really do not have any medical management at the present time to prevent this disease from occurring.

This is of particular note at this point because there are several advances on the horizon, drugs which may prevent the formation or cause the regression of this entity that leads us to appropriate thinking concerning a center for benign prostatic hypertrophy at this point. Therefore, the NIDDKD committee concluded there was sufficient reason to believe that the proposed center's program was scientifically feasible, would contribute positively to advance research knowledge and therapeutic approaches relative to end-stage renal disease and benign prostatic hypertrophy, and NIH therefore concluded they were supportive of the concept of kidney and urological disease centers which we do not have at the present time. Therefore, my main recommendation today is that six centers for renal and urological research be funded with appropriate additional resources, and of course, as urologists, we would hope that a prime concern of these centers be dedicated toward obstructive disease of the urinary tract including benign prostatic hypertrophy.

In addition, I think, as you know, an advisory board has been established for kidney and urologic disease, and we thank you for the establishment of that board, and would like to express our hope that funding will be continued for the advisory board.

There are a number of other things that I have in my written report to the committee, but in view of the time I thank you for allowing me to say these words.

[The statement of Dr. Vaughan follows:]

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TESTIMONY OF

E. DARRACOTT VAUGHAN, JR., M.D.

ON BEHALF OF

THE AMERICAN UROLOGICAL ASSOCIATION

AND

THE AMERICAN ASSOCIATION OF CLINICAL UROLOGISTS

AND

THE SOCIETY OF UNIVERSITY UROLOGISTS

REGARDING FY 1987 APPROPRIATIONS

FOR

THE NATIONAL INSTITUTES OF HEALTH

BEFORE THE

HOUSE SUBCOMMITTEE ON LABOR-HHS-EDUCATION APPROPRIATIONS

APRIL 29, 1986

81st Annual Meeting – May 18 - 22, 1986 – New York Hilton and Sheraton Centre, New York, NY

I am E. Darracott Vaughan, Jr., Chairman of the Division of Urology at The New York Hospital-Cornell Medical Center and Chairman of the Research Committee of The American Urological Association. I am presenting this testimony on behalf of The American Urological Association whose membership of 6,200 represents the majority of American Urologists. I also represent The American Association of Clinical Urology and The Society of University Urologists.

Mr. Chairman, this has been an exciting year for the field of urology research. Space precludes extensive discussion of the many advances however let me review some of the most important. New technology including Extracorporeal Shock Wave Lithotripsy (ESWL) and ultrasonic methods for kidney stone destruction have virtually eliminated the need for the surgical removal of stones. Moreover new drugs are available to prevent stone recurrence.

Successful management of testicular and more recently bladder cancer with multidrug chemotherapy even in patients with extensive disease is now possible. Immunotherapy for kidney cancer has reached clinical application with promising early results. In terms of cancer detection, mandatory for identification of potentially curable early disease, ultrasound, magnetic resonance imaging, new tumor markers and flow cytometry have added dimensions to existing tests.

The advances in knowledge concerning the pathophysiology of penile erection has led the NIDDKD in conjunction with the NKF and urologic community to plan a workshop on impotence to be held at NIH in June.

Equally exciting advancements have been made in other urologic areas such as pediatric urology, neurourology, male infertility, incontinence, and urologic infectious disease.

Let me now move on to some specific areas of direct concern to the Appropriations Committee.

First, as you know, in House Report 99-289 the Committee on Appropriations requested an evaluation of the proposal to establish up to six Kidney-Urology Centers focusing, among other things, on obstructive and hereditary diseases of the urological system and kidney.

We understand that in the report sent to the Congress by the National Institute of Arthritis, Diabetes and Digestive and Kidney Diseases it was indicated in the Executive Summary that one of the major goals of a Centers program would be to focus on benign prostatic hyperplasia (BPH). You should know that kidney disease (end stage renal disease) and BPH have combined annual costs in excess of an estimated $4 billion, with those costs increasing steadily, according to that Executive Summary of the report made to the Congress.

Undoubtedly you know that current treatment on benign prostatic hyperplasia is only palliative and deals solely with complications of an already fully developed disease process.

We are pleased to understand that in regard to benign prostatic hyperplasia the National Institutes of Health, and the National Institute of Diabetes, and Digestive and Kidney Diseases in particular, believe that research advances regarding the potential causes of BPH, such as the isolation of testosterone receptors are now at hand. In addition scientists are in the process of isolating and purifying a prostatic growth factor which may cause BPH perhaps acting in concert with testosterone. It is also apparent that BPH causes obstruction to the urinary tract by means of both its bulk size and the tone or tension that it exerts around the urethra. Drugs are now being developed which should act to decrease the tone thus complementing potential drugs to decrease the bulk of the prostate.

Taken altogether these new approaches to the effective treatment of BPH are so exciting that NIDDKD sponsored a workshop last April gathering all the major scientists working in the area of BPH for discussion. As expected the workshop was highly productive and a number of new grant proposals have been submitted for potential funding.

Hence the NIADDKD report concluded: "Based on an evaluation of these considerations, there is sufficient reason to believe that the proposed centers program is scientifically feasible and that it would contribute positively to advances in research knowledge and therapeutic approaches relative to ESRD and BPH. The NIH is therefore supportive of the concept of kidney and urologic diseases research centers."

Therefore, Mr. Chairman, our first recommendation, resulting directly from the interest in the Congress in benign prostatic hyperplasia, is that these six centers for renal and urological research be funded with appropriate additional resources. Of course, as urologists, we have primary concerns that BPH centers be designated among those centers which should be funded to combat both ESRD and BPH.

In addition, we are pleased to note that you and nearly all the members of your Committee voted overwhelmingly to override the veto of the biomedical research authorization bill last year, which contained a number of new programs relating to urology. We are very hopeful that you will consider funding them this year.

First, a new advisory board has been established known as the National Kidney and Urologic Diseases Advisory Board. As you know, Mr. Chairman, there has been excellent progress made in other fields with the use of advisory boards (Diabetes, Arthritis, and Digestive Diseases Advisory Boards have been established years ago and have been funded by this Committee). We are very hopeful that you will establish funds, or at least insert bill report language in this legislation calling for the funding of a Kidney and Urologic Diseases Advisory Board.

Also, there is an Interagency Coordinating Committee established for Kidney, Urologic, and Hematologic Diseases in the new authorizing legislation. We are very pleased to say that the Urology Research Coordinating Committee established earlier by means of appropriations bill report language is now moving forward well. We look forward to the institution of this new Interagency Coordinating Committee to assure the best possible coordination of kidney and urology research.

There are two other mechanisms which have been established in the authorization legislation, including a Data System (Kidney and Urology Data System), and an Information Clearinghouse for Kidney and Urologic Diseases. We have studied with interest the superior impact that the Data Systems for Diabetes and Arthritis and Digestive Diseases have had in their areas of research, and understand that the Information Clearinghouses for all three disease categories have been very successful.

Mr. Chairman, because your Committee is so very influential in NIH matters, especially as to funding various programs, we would like you to know that the urology research community strongly supports continuing the integrity of the NIDDK, as it is now constituted. As you know, the biomedical research authorization bill passed last year required the Director of the NIH to review the existing research programs within our institute to see if they should remain, or be re-established in another institute.

We support, in the strongest terms, the continuation of the Kidney, Urology and Hematology cluster as it now exists. We are interdependent in research matters, and believe those portions of the kidney and hematology program now in this institute remain there.

In regard to our overall recommendations for funding, Mr. Chairman, we note that the proposed Administration budget for the NIH, for the NIDDK, and for all elements within NIDDK, is essentially below the fiscal year 1986 agreed upon levels.

We thank this Committee for not agreeing to go along with the President's proposed rescissions regarding the NIDDK, but wish you to know that the Gramm-Rudman-Hollings cuts of 4 1/2% from the institute's budget worked significant harm against many researchers, because the cuts came at a time when many grants were already made at a near to full funding at peer reviewed levels, and so subsequent grants coming up later in the fiscal year were harmed disproportionately.

We urge the Committee to provide a level of funding of $503 million for this institute (that assumes funds taken out for the new Arthritis, Musculoskeletal and Skin Institute). This level would provide a maintenance of effort at fiscal year 1986 levels.

We also recommend that the total appropriation to the National Institute of Health be 6.07 billion, in support of the Ad Hoc Group for Health Research funding.

Again, Mr. Chairman, we are deeply grateful to you for your interest in all of biomedical research, but especially your concern about research in urology.

I would be pleased to answer any questions you may have.

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FACT SHEET

FOR APPROPRIATIONS TESTIMONY IN APRIL, 1986

The American Urological Association and the American Association of Clinical Urologists make the following recommendations to the Senate and House Subcommittees on Appropriations for Labor-HHS-Education programs:

1. We strongly support the NIH report to the Congress requested in House Report 99-289, accompanying the appropriations bill which called for an evaluation of the proposal to establish up to six Kidney-Urology Research Centers. Particularly we support the NIH conclusion that one of the major goals of such a centers program would be to focus on benign prostatic hyperplasia (BPH). This is an area ready for considerably more research, as the disease affects the majority of men over the age of 60.

2. We request appropriations to fund the new instrumentalities established by the recently passed biomedical research authorization legislation, including (all within the NIDDK):

   a. Kidney and Urology Advisory Committee,

   b. Kidney and Urology Data System,

   c. Kidney and Urology Education and Information Clearinghouse,

   d. Interagency Coordinating Committee for Kidney, Urology and Hematology Research.

3. We recommend support for the NIDDK Coalition's request for a budget of $504 million for the institute.

4. We recommend support for the Ad Hoc Committee for Biomedical Research proposed budget of $6.07 billion for the N.I.H.

5. We express concern that a device be instituted in some fashion which would assure the level of appropriations not be reduced by a second year of Gramm-Rudman-Hollings cuts.

   We recognize that the Adminsistration's proposed budget for FY 1987 is in fact lower than that originally provided in FY 1985, and suggest that in fact such a level would cause a decrease in research activity by more than 10%, given the costs of the biomedical research inflation levels.

Mr. NATCHER. Thank you very much, Dr. Vaughan. You have given us an excellent statement. We appreciate your appearance.

Dr. VAUGHAN. Thank you.

TUESDAY, APRIL 29, 1986.

EDUCATION PROGRAMS

WITNESS

KENNETH F. MELLEY, DIRECTOR, GOVERNMENT RELATIONS, NATIONAL EDUCATION ASSOCIATION

Mr. NATCHER. Our next witness is Mr. Kenneth F. Melley. We will be pleased to hear from you at this time.

Mr. MELLEY. Thank you, Mr. Chairman. Mr. Conte, it is a great pleasure to be here.

Over the years we have worked with this committee on public education appropriations, and there is indeed a great deal of gratitude to express to you from the members of the National Education Association, members of the Kentucky Education Association, and the Massachusetts Teachers Association. We truly appreciate it.

I am Ken Melley, Director of Government Relations/Political Affairs for the 1,800,000-member National Education Association. Our members include the faculty and staff of this nation's public elementary, secondary, vocational and postsecondary schools, men and women who demonstrate—through their lives and their work—their strong commitment to the continued greatness of this country through the education of its children.

We deeply appreciate this opportunity to testify on the funding of education programs for fiscal year 1987—an issue that will have far-reaching implications on the direction and substance of national education policy for the rest of this century.

We recognize that this subcommittee has some very hard choices before it. Our present economic situation—marked by enormous Federal deficits and increasing social needs—limits the available resources. But we trust this subcommittee will continue to do what it has done in the past—recognize that education is an essential investment in our national life: a critical element in the well-being of our people, the expansion of our economy, and the security of our country. Indeed, public education is the cornerstone of our society, the foundation on which our national and personal goals are built.

This subcommittee has been in the forefront of the Congressional effort to enhance the quality of American education. We are confident that you will continue that vital support. Despite the support of the Congress, education has lost significant ground to inflation and previous budget cuts over the past five years. Ironically, this comes at precisely the time the American people are expressing their clear and firm support for a new drive for excellence in our public schools—a drive that they know will take additional resources, resources they are willing to provide.

We believe it is essential that education funding be brought to the level at least equivalent to the 1980 level at the earliest possible time. The Federal Government must become a full partner in the quest for excellence, in America's education, by providing new and expanded assistance to help improve the quality of instruction and student achievement in our public schools.

We recognize that in the current political and economic climate such a goal can be attained only over time. As a further step, we ask that you assure that education funding does not slide any further backward by providing appropriations for fiscal year 1987 that are equivalent to those passed by the Congress for fiscal year 1986, prior to the imposition of the March 1st Gramm-Rudman cut, plus an adjustment for last year's inflation.

Moreover, it is essential that we begin to add back previously lost revenues, especially any programs serving the disadvantaged, like Chapter 1.

Public education is at a crucial time in its history. Since well before the findings of the Department of Education study, "A Nation at Risk," the American people have called for the improvements in free universal public education. The administration's response has been to propose an education budget for 1987 that would betray this well-established mandate of the American people, limit the opportunities for millions of young Americans, and jeopardize our country's economic future.

Under the President's budget, funding for the United States Department of Education would be reduced to $15.2 billion in fiscal year 1987—$3,200,000 less than the amount originally appropriated by the Congress for fiscal year 1986. The administration's recommendations fall more than $7,300,000 short of what would be needed just to maintain fiscal year 1980 funding levels after accounting for inflation. Moreover, the administration would reverse recent gains in educational excellence by decreasing the U.S. Department of Education funding to $14,000,000 in 1991.

The administration's proposals for education funding must be rejected. The Federal role in public education is a small but a vital one. Federal funds account for 90 percent of the money States spend on remedial education programs and 80 percent of all the student aid funding available for college grants and loans. According to the NEA's ranking of the States, 1985—and I would like to submit that for the record here today—in 1983-84 Federal funds accounted for between 10 and 17 percent of all education resources in 12 States, and between 8 and 10 percent in nine other States. The reductions proposed by the Department of Education may seem small in terms of total education spending, but they could be devastating to the programs that they fund.

Consider the present state of Federal education programs. Education services have been drastically reduced since 1980. Adjusting for inflation, programs in the Department of Education have been cut by more than 38 percent. It would cost $22,500,000,000 just to maintain the same level of services provided in 1980.

The most dramatic losses have been in elementary and secondary education programs. In fiscal year 1980, the cost of elementary and secondary education programs administered by the U.S. Department of Education was $7,300,000,000. It would cost $10.1 billion to serve the same number of children in fiscal year 1987. The Department of Education likes to talk about level funding since this administration took office, but in terms of children served, that freeze has been a freeze out.

The toll on students has been devastating. Approximately 1,000,000 fewer eligible students are served in Chapter 1 programs since the 1980-81 school year. The percentage of eligible students served in Chapter 1 has dropped to 31 percent. The Department of Education estimates that a freeze in the Chapter 1 program for fiscal year 1987 would necessitate the elimination of 260,000 more students eligible for compensatory education services. In the bilingual education programs, 130,000 fewer students are being served in fiscal year 1986 than were in fiscal year 1980. The Federal share of handicapped education programs has dropped from 12 percent to approximately 8 percent.

At the same time, the ability of States and localities to generate new revenue is dwindling. According to the National Governors' Association, 23 States will have revenue shortfalls in fiscal year 1986; 20 States will reduce their budgets in fiscal year 1987.

The issue, Mr. Chairman, is not the compassion of the Members of Congress. In cold, fiscal terms, it is in our interest as a nation to invest in programs that will help "at risk" children and youth function as productive members of society.

Mr. Chairman, without a strong system of public education there can be no national security, there can be no economic development, there can be no progress in any area. The progress in public education which leads to progress in every other area of our national life is a direct result of educational partnership at Federal, State and local levels.

In conclusion, America can generate new opportunities for growth and prosperity and raise the quality of life for its people, but like any other enterprise it will take a sound investment. Public education is such an investment. NEA urges you to fully fund these vital programs, safeguard reform and any further cuts that might be coming along and assure that need-based programs such as Chapter 1 are fully funded.

Thank you very much, Mr. Chairman.

[The statement of Mr. Melley follows:]

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LEGISLATIVE INFORMATION

TESTIMONY OF THE
NATIONAL EDUCATION ASSOCIATION
ON EDUCATION APPROPRIATIONS FOR FISCAL YEAR 1987

BEFORE THE

SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION

OF THE

COMMITEE ON APPROPRIATIONS

U.S. HOUSE OF REPRESENTATIVES

PRESENTED BY

KENNETH F. MELLEY

DIRECTOR, GOVERNMENT RELATIONS/POLITICAL AFFAIRS

NATIONAL EDUCATION ASSOCIATION

APRIL 29, 1986

MARY HATWOOD FUTRELL, President • KEITH GEIGER, Vice President • ROXANNE E. BRADSHAW, Secretary-Treasurer
DON CAMERON, Executive Director
(202) 822-7300

Mr Chairman and Members of the Committee:

I am Ken Melley, Director of Government Relations/Political Affairs for the 1.8 million-member National Education Association. Our members include the faculty and staff of this nation's public elementary, secondary, vocational and postsecondary schools, men and women who demonstrate -- through their lives and their work -- their strong commitment to the continued greatness of this country through the education of its children.

We deeply appreciate this opportunity to testify on the funding of education programs for fiscal year 1987 -- an issue that will have far reaching implications on the direction and substance of national education policy for the rest of this century.

We recognize that this Subcommittee has some very hard choices before it. Our present economic situation -- marked by enormous federal deficits and increasing social needs -- limits the available resources. But we trust this Subcommittee will continue to do what it has done in the past -- recognize that education is an essential investment in our national life: a critical element in the well-being of our people, the expansion of our economy, and the security of our country. Indeed, public education is the cornerstone of our society, the foundation on which our national and personal goals are built.

This Subcommittee been in the forefront of the Congressional effort to enhance the quality of American education. We are confident that you will continue that vital support. Despite the support of the Congress, education has lost significant ground to inflation and previous budget cuts over the past five years. Ironically, this comes at precisely the time the American people are expressing their clear and firm support for a new drive for excellence in our public schools -- a drive that they know will take additional resources; resources they are willing to provide.

It is in this context that we bring you our recommendations today. Our ultimate goal is clear. We believe that it is essential that education funding be brought to a level at least equivalent to that of 1980 as soon as possible. Moreover, the federal government must become a full partner in the quest for excellence in American education by providing new and expanded assistance to help improve the quality of instruction and student achievement in our public schools.

At the same time, we recognize that in the current political and economic climate, such a goal can be attained only over time. As a first step, we ask you -- at the very least -- to assure that education funding does not slide any further backward. Appropriations for Fiscal Year 1987 should be at least equivalent to those passed by the Congress for Fiscal Year 1986 -- prior to the imposition of the March 1 Gramm-Rudman cuts -- plus an adjustment for this last year's inflation. Moreover, it is essential that we begin to add back previously lost resources for programs serving the disadvantaged such as Chapter 1.

A Critical Moment

Public education is at a crucial time in its history. Since well before the findings of the Department of Education's study, A Nation at Risk, the American people have called for improvements in our system of free, universal public education. The Administration's response has been to propose an education budget for 1987 that would betray this well-established mandate of the American people, limit the opportunities for millions of young Americans, and jeopardize our country's economic future.

Under the President's budget, funding for the U.S. Department of Education would be reduced to $15.2 billion in FY87 -- $3.9 billion less than the FY85 appropriation level and $3.2 billion less than the amount originally appropriated by the Congress for fiscal year 1986. This would represent a 20 percent reduction in just two years -- without even taking into account the effects of past budget cuts or inflation. In fact, the Administration's recommendations fall more than $7.3 billion short of what would be needed just to maintain fiscal year 1980 funding levels after accounting for inflation. Moreover, the Administration would exacerbate these reductions with even greater cuts in the future. The President's budget projects decreasing U.S. Department of Education funding to $14 billion by 1991.

The Administration's proposals for education funding are unacceptable and must be rejected. The federal role in public education is a small but vital one. Federal funds account for 90 percent of the money states spend on remedial education programs and 80 percent of all student aid funding available for college grants and loans. According to NEA's Ranking of the States, 1985, in 1983-84 federal funds accounted for between 10 and 17 percent of all education resources in 12 states and between 8 and 10 percent in 9 other states. The reductions proposed by the Department of Education may seem small in terms of total educational spending, but they could be devastating to the programs they fund.

Consider the present state of federal education programs. Education services have been drastically reduced since 1980. Adjusting for inflation, programs in the Department of Education have been cut by more than 38 percent. According to Fiscal Planning Services, Inc., it would cost $22.5 billion just to maintain the same level of services provided in FY 1980.

The most dramatic losses have been in elementary and secondary education programs. In FY 1980, the cost of elementary and secondary education programs administered by the U.S. Department of Education was $7.3 billion. It would cost $10.1 billion to serve the same number of children in FY 1987. The Department of Education likes to talk about level funding since this Administration took office, but in terms of children served, that freeze has been a freeze out.

The toll on students has been devastating. According to U.S. Department of Education figures as contained in the 1980 Federal Budget and the 1986 Federal Budget, 1 million fewer eligible students are served in the Chapter 1 program than in the 1980-81 school year. According to Congressional Research Services the percentage of students served in Chapter 1 has dropped to 31 percent of those eligible. The Department of Education estimates that a freeze in the Chapter 1 program for FY 1987 would necessitate the elimination of 260,000 more students eligible for compensatory education services. In the bilingual education programs, 130,000 fewer students are being served in FY 1986 than were in FY 1980. The federal share of handicapped education programs has dropped from 12 percent to approximately 8 percent.

At the same time, the ability of states and localities to generate new revenue is dwindling. According to the National Governors' Association, 23 states will have revenue shortfalls in FY 1986; 20 states will reduce their budgets in FY 1987.

The issue, Mr. Chairman, is not the compassion of the Members of Congress. In cold, fiscal terms, it is in our interest as a nation to invest in programs that will help ``at risk`` children and youth function as productive members of society. The correlation between those who fail to finish school and those who are chronically unemployed is clear. The correlation between disadvantaged students who have access to compensatory education programs and those who later have high levels of success in their school careers is also well-established. The same is true of programs for the handicapped. Programs -- mandated and partially funded by the federal government -- to assist handicapped children and youth lead to high rates of social integration and individual success in later life. Clearly these are suitable goals for our nation, not only from a moral standpoint, but as a nation which seeks to invest its resources wisely in a time of limited resources.

The following are some observations regarding a number of programs administered by the U.S. Department of Education. They serve, not as an exhaustive list, but as an indication of the dire need to fund federal education programs.

Chapter 1

As stated earlier, more than 1 million fewer educational disadvantaged students will have access to compensatory education services under the Chapter 1 program in the 1985-86 school year than did in 1980-81. There is no question that these programs are among the most successful federal education programs now available, that participants show dramatically higher scores in reading and math, and that the earlier students have access to these programs, the less need there is for further remedial programs. The issue is not the number of dollars the federal government spent in one year compared to another, but the great unmet needs of American students. At the very least, Congress must provide an inflation adjustment sufficient to maintain current services. But Congress must also close the gap between students in need of service and available programs.

Chapter 2

Chapter 2 funding, which allows state flexibility to fund specific needs, encourages the type of innovation necessary to revitalize our nation's schools. The uncertainty of Chapter 2 funding levels in recent years has discouraged states and school districts from meeting the personnel needs of these projects. Adequate and consistent funding levels for Chapter 2 programs will improve the ability of school districts to establish model programs to serve a wide variety of student needs.

Vocational Education

In America's rapidly changing workplace, career training and retraining programs are of extreme importance in the economic security of our nation. The highly sophisticated tools of today's workers are constantly evolving, and those who operate, program, and repair these tools require levels of training that can only be achieved in an educational setting which reflects today's workplace. Funding for access to vocational programs for America's disadvantaged students, which the Administration supports, is of little or no value, if we do not also address equipment and program needs for training in manufacturing, service, and information industries.

Impact Aid

The contention that a local government's ability to generate local revenues sufficient to fund public schools is not harmed by the presence of federal property is wholey without basis. If this Administration is sincere about its contention that local citizens should maintain the responsibility for funding school programs, then it should recognize that when the federal government is acting in the capacity of a local resident, it too should bear its fair share.

Bilingual Education

After six years of a spending freeze, the federal share of bilingual education programs has shrunk from approximately $485 per pupil in FY 1980 to approximately $300 per pupil in FY 86. To maintain the same level of service -- adjusted for inflation -- would cost approximately $670 per student. Some 130,000 fewer students have access to bilingual education programs in 1985-86 than in 1980-81. Our young people need skills in English to make it both in the schools and in the workforce, but they also need assistance in making the transition. What more fitting tribute to the anniversary of the Statue of Liberty could Congress make than to fully fund the needs of this program and live out the promise the Statue of Liberty represents?

Handicapped Education and Vocational Rehabilitation

Since the passage of P.L. 94-142, hundreds of thousands of young people have been integrated into the schools, and thus into society. The benefits of education for the handicapped go far beyond the successes of the individual student. Education of the handicapped is a moral and economic necessity for this country. The U.S Department of Education predicts that 30,000 more handicapped students will need services in the 1986-87 school year, than in the 1985-86 school year. Increases in budget authority to pay for these new students is absolutely crucial to the success of these programs. A cut, as proposed by the Administration, or even a freeze, will seriously hamper the ability of local school districts to offer adequate educational services for these students.

Vocational Rehabilitation programs for handicapped students are an investment in human resources which pays great dividends in higher productivity and lower demand for other social services. The federal share of the excess costs of these programs has dropped from approximately 12 percent to about 8 percent. Increases to slow this gap in the federal commitment must be made to assist local schools districts and meet the needs of both the individual students served by these programs and our nation as a whole.

Postsecondary Student Assistance

College costs continue to rise at a rate much higher than inflation, even as the amount of total student aid -- federal, state and institutional -- has dropped. The Congressional Budget Office reports that total student charges rose 53 percent between 1980 and 1986 while the Consumer Price Index has risen 36 percent. Average college costs are expected to rise from approximately $6,400 in 1985-86 to $6,800 in 1986-87 and $7,600 in 1988-89.

According to the College Board, in 1983-84 about 93 percent of the Pell Grant funds were provided to students in families below $20,000 income. In that same year, 40 percent of the Guaranteed Student Loan recipients came from families with incomes below $15,000, and almost 70 percent of the GSL recipients came from families with incomes below $30,000.

Even with the current level of postsecondary student aid, the costs of higher education are causing countless qualified young people to defer or forgo postsecondary education. Yet the Administration's proposal would force hundreds of thousands more out of federal assistance programs. The implications for society are frightening in terms of intellectual, technological, and economic growth. These student aid programs must be fully funded.

Higher Education Institutional Aid

Funding for access is meaningless without adequate funding for improving and sustaining academic programs. Federal assistance for improving postsecondary institutions is vital to our nation's continued success.

Conclusion

Mr. Chairman, without a strong system of public education, there can be no national security, there can be no economic development, there can be no progress in any area. The progress in public education, which leads to progress in every other area of our national life, is a direct result of an educational partnership of federal, state, and local governments.

America can create new opportunities for growth and prosperity. We can bring up the quality of life for all Americans. But like any other enterprise it will take a sound investment. Public education is such an investment. NEA asks that you help lead this country into a future filled with promise. We urge you to fully fund these vital programs, safeguard education from any further cuts, and assure that need-based programs -- such as Chapter 1 -- are able to fully serve the needs of American students. With adequate federal support, we can provide a system of public education that is more than adequate. We can provide excellence.

Thank you.

Mr. NATCHER. Thank you, Mr. Melley. You have given us an excellent statement, and we appreciate your appearance at this time.

Mr. MELLEY. Thank you, sir.

TUESDAY, APRIL 29, 1986.

HIGHER EDUCATION

WITNESS

JOHN S. TOLL, PRESIDENT, UNIVERSITY OF MARYLAND

Mr. NATCHER. Our next witness is Dr. John S. Toll. Come around, Dr. Toll.

Doctor, it is a pleasure to have you back before the committee. We will be pleased to hear from you.

Mr. TOLL. Thank you very much, Chairman Natcher, Congressman Conte, Congressman Stokes. I am John Toll, President of the University of Maryland, with headquarters 25 minutes' drive from here. I am here today representing the 14 major national associations that represent postsecondary education here in Washington, including the American Council of Education and others listed in my testimony. I assume my whole testimony will be in the record and I will therefore abbreviate it at this time.

Our highest priority for fiscal year 1987 is placed on the student aid program through which the Federal Government provides 75 percent of the total national expenditures for scholarship assistance. These programs are therefore truly essential to maintain the nation's opportunities for postsecondary education.

Although the administration is determined to sharply diminish this Federal role, the importance has been recognized in the past by this subcommittee and by the Congress, and we thank you for the key leadership role that you have played.

Our critical capacity to develop human resources is eroding even as the need grows more urgent. The number of students in the Pell grant program whose families are too poor to contribute anything to their education according to the national means test would total 1,700,000 next fall as compared with 1,200,000 six years ago. Two-thirds of the 2,800,000 Pell recipients have family incomes below $10,000 a year. These are precisely the students who most need Federal aid to obtain postsecondary education. The lower the family income the less the chance of college attendance.

For example, if you look just at high ability students, those in the low income group have twice as many in proportion not attending higher education than those in the high income group. This gap is likely to increase, unless Federal aid increases substantially, because of the marked decline in mean family income in recent years.

First, Mr. Chairman, just to hit high points, I would like to talk about the fiscal year 1986 supplemental grant which is especially important to us. Our first request is that you provide for the supplemental fiscal year 1986 appropriation for Pell grants the amount that is necessary to maintain current eligibles in the program for which the administration has failed to request. As we wrote to you last February 9—and I hope the American Council of

Education two-page letter can be entered into the record to supplement my remarks—the Pell program for this coming academic year is now $369,000,000 short of the amount needed to assist all needy students currently eligible for award. Some $215,000,000 of this is due to the increases in the number of eligible students. $154,000,000 additional is due to the March 1 Gramm-Rudman-Hollings sequestration of funds.

Without a supplemental grant, the full $369,000,000 will have to be cut from the program by application of the statutory reduction formula. This would have a devastating effect. In my written testimony I give the estimates that were made by the administration. Since that was prepared, the Congressional Budget Office has reestimated and found that there would be 340,000 students who would be cut from the program entirely, and an additional 640,000 recipients from families with incomes down to $12,000, to the result would be to cut just about 1,000,000 students very substantially.

Our highest priority for fiscal year 1987 is, again, the Pell grant. The discussions in the Senate would indicate that there is a budget resolution which will generally freeze spending ceilings with possible adjustments for inflation. If you assume such a current services budget, and we ask that all the additional funding be used first to provide for maintaining the Pell grant program as our highest priority. That amount would be about sufficient to keep pace with inflation for Pell grants, perhaps also for supplemental grants to be distributed equitably to needy students.

An increase in Pell grants is necessary if we are to avoid many, many low-income students dropping out of higher education, and those that remain having to assume unreasonable debts. Increases are needed on other campus-based programs as well. We have supplied details in my testimony, proposed $45,000,000 increase in the supplemental grants, $96,000,000 increase in the direct loans, $28,000,000 for the college work-study, and level funding for the State student incentive grants which are matched by the States.

For graduate fellowships there is also an important need. These are authorizes under Title IX of the Higher Education Act. These are among the few Federal programs of support currently available to strengthen minority participation graduate education, are the only source of specific Federal predoctoral support in the humanities. Three years ago the National Commission on Student Financial Assistance reported that Federal support is indispensable to excellence in graduate education, which is showing serious signs of distress. The number of federally supported fellowship programs for graduate education has dropped to one quarter of what it was a decade ago.

We recommend a modest $5,000,000 increase over fiscal year 1986 appropriation level for graduate and professional opportunities programs, and the national graduate fellowships, as well as continued funding for the public service fellowships, assistance for training in the legal profession, and the law school clinical experience. Even with these fundings we will still be far below the level that is really necessary to meet the needs for graduate education in the nation.

Mr. Chairman, I am pleased to answer any questions that you or other members have. I see Congressman Hoyer is here. I am pleased to recognize a distinguished graduate of our institution. We are proud to have him as a Member of your committee.

[The statement of Mr. Toll follows:]

TESTIMONY
TO THE
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION
COMMITTEE ON APPROPRIATIONS
U.S. HOUSE OF REPRESENTATIVES

APRIL 29, 1986

PRESENTED BY

PRESIDENT JOHN S. TOLL

UNIVERSITY OF MARYLAND

ON BEHALF OF:

American Association of Community and Junior Colleges
American Association of State Colleges and Universities
American Council on Education
Association of American Universities
Association of Catholic Colleges and Universities
Association of Jesuit Colleges and Universities
Association of Urban Universities
Council of Independent Colleges
National Association for Equal Opportunity in Higher Education
National Association of College and University Business Officers
National Association of Independent Colleges and Universities
National Association of Schools and Colleges of the United Methodist Church
National Association of State Universities and Land-Grant Colleges
National Association of Student Financial Aid Administrators

Mr. Chairman and Members of the Subcommittee:

I am John S. Toll, President of the University of Maryland. I am here to present the recommendations of several national associations for the higher education programs of the Department of Education budget.

Our highest priority for FY 87 is placed on the student aid programs through which the federal government provides 75 percent of total national expenditures for scholarship assistance. These programs are essential to maintain the nation's commitment to postsecondary opportunities.

While the Administration would sharply diminish this federal role, its importance has been strongly supported by this Subcommittee and by the Congress. The vital role of higher education in strengthening the nation's economic base has been acknowledged by numerous studies, including the President's Commission on Industrial Competitiveness. Just a few weeks ago, the White House Science Council Panel recommended that the federal government "make substantially greater investments in our centers of learning in the 1980's and 1990's" to meet the nation's need for scientific and technical talent.

Yet our critical capacity to develop human resources is eroding as the need is growing more urgent. The number of students in the Pell Grant program whose families are too poor to contribute anything to their education will total 1.7 million next fall, as compared to 1.2 million six years ago. Two-thirds of the 2.8 million Pell recipients have family incomes below $10,000; almost 90 percent have family incomes below $20,000.

These are precisely the students who most need federal aid to obtain postsecondary education. The lower the family income, the lesser the chances of college attendance: for example, 86 percent of 1980 graduating high school seniors with high academic ability and high family income went directly to college, compared to 62 percent of high-ability students from low-income families.

This gap is likely to increase unless federal aid increases substantially, because of a marked decline in mean family income in recent years. Between 1973 and 1984, the mean income for all families with children declined 8.3 percent. According to a recent analysis for the Joint Economic Committee, poverty is increasing for families with children because of the growth in the number of families headed by females, the increased incidence of low earnings among male heads of families, and the decline in the real value of transfer payments to poor families with children.

But as the need for student aid increased, the value of federal aid suffered further erosion last year as appropriations were frozen at FY 85 levels and then cut 4.3 percent below that by the March 1 Gramm-Rudman-Hollings sequestration. We urge the Subcommittee not to permit further erosion in FY 87.

America's colleges and universities have pressing needs, not only for student aid, but for support to strengthen the quality of education at the undergraduate and graduate levels, and to address serious deficiencies in academic and laboratory facilities. Nevertheless, we recognize that these needs must go unmet due to the exigencies of the Gramm-Rudman-Hollings deficit reduction goals.

In the expectation of a budget resolution for FY 87 which will generally freeze spending ceilings, with some possible adjustment for inflation, our highest priority is for those programs of the Higher Education Act that provide student access and choice of postsecondary education. Under a "current services" budget, additional funding in the range of $200-$300 million would be available for these programs. That would be sufficient for the Pell maximum to keep pace with inflation, for Supplemental Grants to be distributed equitably to needy students in both public and independent institutions, and for other student aid programs to be maintained at their current value.

FY 86 Supplemental

Our first request is that you provide the supplemental FY 86 appropriation for Pell Grants that is necessary to maintain current eligibles in the program, but which the Administration has failed to request. As we wrote you last February 19, the Pell program is now $369 million short of the amount needed to assist all needy students currently eligible for awards. Some $215 million of this is due to increases in the number of eligible students; $154 million is due to the March 1 Gramm-Rudman-Hollings sequestration.

Without a supplemental, the full $369 million will have to be cut from the program by application of the statutory reduction formula. This would be devastating to needy students throughout the country. We estimate that it would remove some 290,000 students from the program entirely, and require substantial reductions in the awards of another 500,000 recipients from families with incomes down to $12,000. For example, students from families with incomes of $20,000 would have their grants cut by $600; students with $15,000 family income would be cut by $200; the effective upper limit on eligibility would be reduced from $26,500 to $21,500 for a family of four with one in college.

To impose such extensive cuts would force hundreds of thousands of students to alter their college plans drastically or drop out entirely. We are certain this was not the intent of the Subcommittee in stating its assumption, during passage of the FY 86 appropriation bill last December, that no supplemental would be needed.

FY 87 Appropriations

Pell Grants

Our highest priority is to protect the Pell Grant--the basic foundation for all student assistance--from the erosion of inflation. There has already been a serious decline in the value of the Pell award since the beginning of the program, when the maximum represented 45 percent of average cost of attendance at all institutions (30 percent for students at independent institutions). In Academic 87-88, the $2,100 maximum will meet only 29 percent of average costs (18 percent for students at higher-priced institutions).

An increase in Pell benefits is necessary to avoid low-income students dropping out or assuming unreasonable debt. We recommend a $150 million increase from the FY 86 appropriation level to maintain current eligibles in the program and increase entitlements by $100 to maintain approximately their current value.

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Increases are needed in the campus-based programs fully as much as in the Pell program. According to data submitted by colleges applying for aid for Academic Year 85-86, over $3 billion more is needed to achieve the statutory goal of covering 75 percent of student expenses through federal grants and family contributions.

Supplemental Grants

We propose a $45 million increase from the FY 86 appropriation level for Supplemental Grants to bring the program to the statutory $440 million required when the Pell maximum exceeds $2,099. This would provide some 80,000 additional awards for undergraduate students with substantial financial need. An estimated 700,000 are to be made this fall under the FY 86 appropriation. Although the Administration has proposed its elimination, SEOG is especially critical for needy students attending higher-priced public and independent institutions. Ninety-eight percent of SEOG recipients receive other forms of student aid; two-thirds of recipients are from families with incomes under $20,000.

Direct Loans

A $96 million increase from the FY 86 appropriation level for federal capital contributions to Direct Loans would restore the program to its statutory $286 million level required when the Pell maximum exceeds $2,099. This would support an additional 120,000 low-cost loans for needy students in addition to the 240,000 which will be funded by the FY 86 appropriation. NDSL capital contributions are needed by some 2,500 institutions which would otherwise have to cut back on these loans substantially; these institutions report a need for additional NDSL funding in excess of $1 billion.

College Work-Study

We also recommend a $28 million increase from the FY 86 appropriation level for the College Work-Study program. This would provide an additional 40,000 self-help opportunities and bring total funding for the program to $620 million.

State Student Incentive Grants

We recommend level-funding for this state-based program at the FY 86 appropriation level of $76 million to maintain awards at approximately 304,000 including state matching. To eliminate this program as the Administration requests would reduce state as well as federal support for needy students in at least 15 states which rely on the federal share for up to 50 percent of total funding.

Graduate Fellowships

Other important student aid programs are authorized by the graduate fellowship provisions of Title IX of the Higher Education Act. These programs are among the few federal sources of support currently available to strengthen minority participation in graduate education, and the only source of predoctoral support in the humanities. Three years ago, the National Commission on Student Financial Assistance reported that "federal support is indispensable to excellence in graduate education," which is showing "serious signs of distress." We recommend a $5 million increase over the FY 86 appropriation level for the Graduate and Professional Opportunities Program (GPOP) and the National Graduate Fellowships, as well as continued funding for Public Service Fellowships, Assistance for Training in the Legal Profession, and Law School Clinical Experience.

Special Programs for the Disadvantaged

We recommend an increase of $20 million to provide current services funding for Upward Bound, Talent Search, Special Services, Educational Opportunity Centers, and staff training grants. These programs are of proven value in encouraging the participation and retention of disadvantaged youth in college. They have suffered some restriction in recent years due to increased costs. The Administration seeks to cut them in half; they should receive an increase to permit wider access to these services.

Categorical Support

The various categorical programs of the Higher Education Act provide assistance for important national purposes. The Administration would eliminate all except Title III grants for developing institutions and the Fund for the Improvement of Postsecondary Education. We insist that support for international studies, research libraries, and cooperative education is needed to strengthen the quality of higher education; we urge their continuation at least at FY 86 levels. As funds become available, we would support increases for these programs, as well as for such currently unfunded programs as college libraries, continuing education, and urban grants.

For the past two years the Subcommittee has provided modest funding for academic facilities grants under Title VII, recognizing the enormous facilities problems on the nation's campuses. We urge that this funding be continued and expanded if possible to permit more institutions to participate, and to prevent unwarranted earmarking of funds for individual institutions. In addition, we ask that revolving funds from the College Housing Loan program continue to be made available for new commitments, to avoid discontinuing this important program.

We also support implementation of the Carl Perkins Vocational Education Act, which points in important new directions in Title III Part C (adult training and retraining) and Part E (partnerships with high-tech industry). Funding of these programs would dramatically expand vocational programming in the private sector by leveraging both high-tech partnerships and adult training for real jobs. Such investments would be repaid many times over in added federal revenue and growth of the national skill base.

Mr. NATCHER. Thank you, Dr. Toll. You have made an excellent statement and we want to thank you for your appearance. I yield to Mr. Hoyer.

Mr. HOYER. Thank you very much.

Dr. Toll, I want to apologize. I was testifying on a bill that I am the principal sponsor of before Congressman Conyers' subcommittee.

Mr. Chairman, Mr. Conte and Mr. Stokes, in my opinion Dr. Toll is one of the most dynamic effective leaders in higher education that we have in this country. He has turned the University of Maryland from a good university into a great university, and he is one of the most respected leaders in our State. I am very appreciative of the leadership he has given to our institution and to higher education.

Doctor, you do an outstanding job and we very much appreciate your presence here today.

Mr. TOLL. Thank you, Mr. Chairman.

TUESDAY, APRIL 29, 1986.

CONSUMER AND HOMEMAKING EDUCATION

WITNESS

JEWELL DEENE ELLIS, EXECUTIVE DIRECTOR, KENTUCKY VOCATIONAL ASSOCIATION, AND CHAIR OF THE COALITION FOR VOCATIONAL HOME ECONOMICS EDUCATION PROFESSIONAL ORGANIZATIONS

Mr. NATCHER. Our next witness is Ms. Ellis. Come around Ms. Ellis. You have been before our committee before. We are pleased to have you today. We will listen to you very carefully.

Ms. ELLIS. Mr. Chairman and Members of the subcommittee, I am Jewell Deene Ellis, Executive Director of the Kentucky Vocational Association and Chair of the Coalition for Vocational Home Economics Education Professional Organizations.

From the earliest legislation to support vocational education to the present, the Congress of the United States has included funding for home economics education.

However, as we meet here today, the existence of consumer and homemaking education programs is threatened because the President's budget for fiscal year 1987 proposes to terminate the line item under Title III, Part B, Special Programs of the Parkins Act.

It is evident that vocational education, including consumer and homemaking education, is being singled out for budget cuts when other major elementary and secondary education programs have not sustained major budget cuts. This seems unreasonable, especially the first year that a new law is being implemented. The administration's proposal leads one to ask why.

Why should line-item funding for consumer and homemaking education be terminated when:

1. Youth and adults are enrolled in programs in practically every community in the nation?
2. It is the only program that has its central focus on the home, the individual, and the family?

3. It is an alternative program for keeping many potential dropouts in school?

4. It serves more disadvantaged students than any other vocational program?

I would like to now address some statements made by our critics by showing you positive examples of what works using consumer and homemaking education dollars.

One of the reasons stated by the Department of Education for terminating funding is that consumer and homemaking education is a "narrow categorized area." How could a program which addresses national priorities and serves 3,900,000 students be termed a "narrow area?" Some of the national priorities currently being addressed across the country include:

1. Helping teen-age parents cope and succeed.
2. Assisting homemakers in economically depressed areas.
3. Applying academic skills (i.e., math, science, writing and consumer skills) to managing a home environment.
4. Enhancing employability skills of youth and adults.
5. Assisting displaced homemakers as they work.

As further evidence of what is done to meet national priorities, I would like to cite three examples. In my own State, Marion County High School has a successful program for teen-age parents. Enrolled are 23 teen-age mothers, 12 seniors and 11 juniors. To quote the teacher of this program, "The students and their parents think the program is super. It has helped students to develop self-esteem and prevented them from dropping out of school." Students studied the responsibilities of parenthood and gained knowledge about normal growth and development of children. Next year, day care will be provided at the school for the children of these parents.

In the State of Iowa, much has been done to serve 32,594 adults in economically depressed areas. For example, grants to two community colleges located in industrial areas have provided assistance to "factory lay-offs." These individuals who once were considered in the middle income bracket are now the new poor who find themselves suddenly unemployed.

Assisting displaced homemakers was a top priority in Ohio. In 1984–85, a total of 1,012 individuals participated in a program designed to remove barriers to employment and achieve family stability. After completion of the programs, 34 percent of those who received skills training were employed.

From these examples it is evident that offerings in consumer and homemaker education are representative of a broad area and cover a wide spectrum of national priorities.

Some critics are of the opinion that Federal funding for vocational education, including consumer and homemaking education, is not necessary as States overmatch the Federal dollars 10 to 1. The fact that States overmatch with State dollars signifies the importance of vocational education, including consumer and homemaking education.

If Kentucky is typical of other States across the nation, however, State dollars to replace Federal dollars are not plentiful. The Kentucky legislature has just ended its session and approved a budget for the next two years, which contained no new dollars for vocational education. The elimination of line-item Federal funding for consumer and homemaking education would greatly reduce the number of programs which in turn would deny students participation in the "ladder of opportunity," to which the President himself made reference in his State of the Union address only this year.

To those who question whether the Federal dollars make any difference, I maintain that these funds provide the incentive leading to quality programs. For example, these funds make it possible for consumer and homemaking teachers to travel to regional and State conferences designed to keep them up to date.

Another use of travel funds is supervision of students who are members of the vocational student organization, Future Homemakers of America (FHA). As a testimony to the impact that future homemakers have on communities, I have included in the written testimony a letter to the State FHA Adviser in Kentucky. The writer is editor of the Allen County News in Scottsville, Kentucky, and chairman of the Home Economics Advisory Committee in a neighboring town in Tennessee.

Another example of how Federal dollars contribute to quality is the purchase of up-to-date equipment for classroom instruction.

The last point of discussion refers to critics who say that consumer and homemaking education could be funded through Title II basic grants. To my knowledge, there is no provision for this. But even if it were possible, and States had the opportunity to include consumer and homemaking education in the basic grants, reduction in overall vocational programs and services surely would occur. How could this program survive in basic grants when the administration proposes to cut basic grants by 50 percent? The number of consumer and homemaking education programs in some States would be greatly reduced and in other States these programs would virtually be eliminated. This would mean that many of the provisions of Title III, Part B of the law would not be implemented.

In summary, I urge that funding be continued to ensure quality consumer and homemaking education programs that address national priorities. I believe important programs warrant the continuation of line-item funding.

Mr. Chairman, I commend you and Members of this committee for your record of support for consumer and homemaking education. I appreciate the opportunity to express the values of the coalition regarding consumer and homemaking education.

[The statement of Ms. Ellis follows:]

PREPARED TESTIMONY
FOR THE
HOUSE
APPROPRIATIONS SUBCOMMITTEE FOR EDUCATION
THE HONORABLE WILLIAM NATCHER, CHAIRMAN

PRESENTED BY
JEWELL DEENT ELLIS
AMERICAN HOME ECONOMICS ASSOCIATION
AND
COALITION FOR VOCATIONAL HOME ECONOMICS EDUCATION
PROFESSIONAL ORGANIZATIONS

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APRIL 29, 1986
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Mr. Chairman and members of the Subcommittee:

I am Jewell Deene Ellis, Executive Director of the Kentucky Vocational Association and Chair of the Coalition for Vocational Home Economics Education Professional Organizations.

Thank you for the opportunity to discuss vocational education, including the issue of funding for Consumer and Homemaking Education. Today, I am representing the Coalition for Vocational Home Economics Education which has a combined membership of more than 70,000 individuals from the American Vocational Association (AVA), the American Home Economics Association (AHEA), and the Home Economics Education Association (HEEA).

The relationship of quality home and family life to productive, satisfying work life has been implicit in vocational education legislation. From the earliest legislation to support vocational education to the present, the Congress of the United States has included funding for home economics education. The funding for the occupation of homemaking implies that the role of family life and the functioning of households to economic, social, and political well-being of our Nation is important.

From 1982 to 1984, the Coalition devoted its efforts to the authorization of the Carl D. Perkins Act of 1984 (P.L. 98-524) and worked hard to ensure that Consumer and Homemaking Education would be authorized as a line item, thus providing grants to states to improve, expand, and update programs to meet the changing needs of society.

You and others in the 98th Congress recognized that need and authorized funding for Consumer and Homemaking Education. Last year, in the 99th Congress, you again recognized the need for continued Consumer and Homemaking Education programs when you appropriated funds for them under that line item for FY '86, despite the Administration's proposals to do otherwise. As a result, the Consumer and Homemaking Education programs throughout the country are currently preparing males and females for the occupation of homemaking, also known as life skills, at all educational levels. These programs are not "hand-out" programs. By contrast, they focus on preventive education and address social and economic concerns. These programs enable Americans to be productive citizens who pay taxes instead of citizens who consume taxes.

However, as we meet here today, the existence of Consumer and Homemaking Education programs is threatened because the President's budget for FY '87 proposes to terminate the line item of $31,633,000 under Title III, Part B, for Special Programs of the Perkins Act. The budget proposal seems to be in conflict with the President's philosophy of providing support for families as expressed in his State of the Union address earlier this year. He stated that "families and community are the co-stars of (the) great American comeback." He suggested that the Federal government "create a ladder of opportunity to full employment so that all Americans can climb toward economic power and justice on their own."

The current legislation for Vocational Education, including Consumer and Homemaking Education, as written in the Perkins Act is a vehicle for creating a ladder of opportunity to full employment through quality programs. The legislation which provides line item funding for Consumer and Homemaking Education has greater potential for a ladder of opportunity than in the past because of fewer restrictions in the use of funds. More flexibility in administering the program at the state level makes possible various alternatives for meeting needs of individuals and families.

It is evident that vocational education, including Consumer and Homemaking Education, is being singled out for budget cuts when other major elementary and secondary education programs have not sustained major budget cuts. This seems unreasonable, especially the first year that a new law is being implemented. The Administration's proposal leads one to ask why.

Why should line item funding for Consumer and Homemaking Education be terminated when:

1. Youth and adults are enrolled in programs in practically every community in the nation?
2. It is the only program that has its central focus on the home, the individual, and the family?
3. It is an alternative program for keeping many potential dropouts in school?
4. It serves more disadvantaged students than any other vocational program?

For the remainder of my testimony, I want to address some statements made by our critics by showing you some positive examples of what works using Consumer and Homemaking Education dollars.

One of the reasons stated by the Department of Education for terminating funding is that Consumer and Homemaking Education is a "narrow categorized area." How could a program which addresses national priorities and serves 3.9 million students be termed a "narrow area?" Some of the national priorities currently being addressed across the country include:

1. Helping teenage parents cope and succeed.
2. Assisting homemakers in economically depressed areas.

3. Applying academic skills (i.e., math, science, writing, and consumer skills) to managing a home environment.
4. Enhancing employability skills of youth and adults.
5. Assisting displaced homemakers as they work.

As further evidence of what is done to meet national priorities, I would like to cite one example of each priority. In my own state, Marion County High School has a successful program for teenage parents. Enrolled are 23 teenage mothers, 12 seniors and 11 juniors. To quote the teacher of this program, "the students and their parents think the program is super. It has helped students to develop self-esteem and prevented them from dropping out of school." Students studied the responsibilities of parenthood and gained knowledge about normal growth and development of children. Next year, day care will be provided at the school for the children of these parents.

In the state of Iowa, much has been done to serve 32,594 adults in economically depressed areas. For example, grants to two community colleges located in industrial areas have provided assistance to "factory lay-offs." These individuals who once were considered in the middle income bracket are now the new poor who find themselves suddenly unemployed. While instruction varies according to the needs of the individuals, money management and consumerism have high priority.

Another successful program in an economically depressed area is in Des Moine, Iowa, where the prevention of child abuse is addressed through work with abusive parents. Close coordination and cooperation with other agencies have made possible the referrals of parents needing help in this area.

Another priority being addressed in Kentucky and other states is the integration and application of academic skills in Consumer and Homemaking Education. At West Hardin High School, these skills are taught through computer software programs that address such topics as handling a checking account, math and personal finances, and insurance. In this program and others statewide, attention is given to writing projects, reading and following instructions, and preparing and making oral reports.

In response to concerns expressed by employers that employees need instruction in employability skills, Kentucky has expanded its Consumer and Family Life Skills program for post-secondary students. All students enrolled in the 13 state vocational schools must participate in the program. In addition to the component on Employability Skills, Consumer Economic Skills and Life Skills are taught in the 60 hour course. Currently, 3,000 males and females are enrolled.

Some of the priority competencies in the Employability Skills component are developing good work habits and attitudes, identifying sources of jobs available, preparing a resume with a cover letter, completing a job application, determining take home pay, and balancing the dual role of wage earner/family members. The principal of one of the schools in Western Kentucky said that instruction received in attitudes, management of time and money, and study skills were key factors in helping students to keep jobs once they were employed. One teacher who has taught the course for five years said, "It is the most important program in the school. For some students, it is their last hope to receive help with communication techniques, work attitudes, and work habits."

In the state of Ohio, assisting displaced homemakers was a top priority in 1984-85. A total of 1,012 individuals participated in a program designed to remove barriers to employment and achieve family stability. After completion of the programs, 34% of those who received skills training were employed.

From these examples, it is evident that offerings in Consumer and Homemaking Education are representative of a broad area and cover a wide spectrum of national priorities. It is further evident that funds are being used to improve, expand, and update programs.

Some critics are of the opinion that Federal funding for vocational education, including Consumer and Homemaking Education, is not necessary as states overmatch the Federal dollars 10 to 1. The argument is that states would pick up the Federal dollars if eliminated. Another argument is that the Federal dollars make no real difference in providing vocational education. The fact that states overmatch with state dollars signifies the importance of vocational education, including Consumer and Homemaking Education. However, there is a limit of the states' capability to continue this overmatch.

If Kentucky is typical of other states across the nation, state dollars to replace Federal dollars are not plentiful. The Kentucky legislation has just ended its session and approved a budget for the next two years, which contained no new dollars for vocational education. The elimination of line item federal funding for Consumer and Homemaking Education would greatly reduce the number of programs which in turn would deny students participation in the "ladder of opportunity."

To those who question whether the federal dollars make any difference, I maintain that these funds provide the incentive leading to Quality Programs. For example, these funds make it possible for Consumer and Homemaking teachers to travel to regional and state conference designed to keep them up to date. At Kentucky's statewide conference in July 1985, topics on technology related to home economics, motivating disadvantaged students, breaking the cycle of abuse and discipline in the classroom were part of the program. One inservice conducted in the fall of 1985 provided for interpretation and instruction in the use of a new curriculum in Family Violence.

Another use of travel funds is supervision of students who are members of the vocational student organization, Future Homemakers of America (FHA). As a testimony to the impact that future homemakers have on communities. I want to quote, in part, from a letter written to the State FHA Adviser in Kentucky. The writer, who is editor of the Allen County News in Scottsville, Kentucky, and Chairman of the Home Economics Advisory Committee in a neighboring town in Tennessee, had this to say:

> "Lee Graves recently approached me to ask if I would write her a letter of recommendation for a state FHA scholarship. I told her it would be my pleasure and it truly is!
>
> As editor of this community's weekly newspaper, I cover many activities and events at our schools and as a result I have had the opportunity to observe a great many students 'up close' many of whom I have come to admire. Lee Graves is near the top of my admiration list of the students I have seen come and go at Allen County-Scottsville High School.
>
> ...in the past year, since being named a state FHA officer, I have seen Lee blossom almost overnight. You can see the confidence in the way she asserts herself, the manner in which she speaks, the way she dresses, and...the way she smiles. I have seen many outstanding young women emerge from the Tennessee FHA organization whom I have admired. Knowing Lee Graves assures me Kentucky's FHA is turning out young women just as outstanding!"

Another example of how federal dollars contribute to quality is the purchase of up-to-date equipment for classroom instruction. For some institutions, this meant replacing outdated and worn equipment. For others these funds make possible the purchase of computers and audio visual equipment. For some states, quality was the opportunity to revise and/or develop curriculum in parenthood education, child abuse, and family violence.

The last point of discussion refers to critics who say that Consumer and Homemaking Education could be funded through Title II, Basic Grants for Vocational Education in the Perkins Act. To my knowledge, there is no provision for this. But even if it were possible, and states had the opportunity to include Consumer and Homemaking Education in the Basic Grants, reduction in overall vocational programs and service surely would occur. How could this program survive in Basic Grants when the Administration proposes to cut Basic Grants by 50%? The number of Consumer and Homemaking Education programs in some states would be greatly reduced and in other states, these programs would virtually be eliminated. This would mean that many of the provisions of Title III, Part B of the law would not be implemented. For example:

1. There would be fewer dollars for implementing the provisions in Title III, Part B of the Perkins Act.
2. There would be limited or no funding for support services and activities designed to ensure quality of programs.
3. Difficulties would arise in determining that 1/3 of the funds be spent in economically depressed areas.

4. The loss of flexibility would result in administering the Consumer and Homemaking Education program on a statewide basis.

In summary, Consumer and Homemaking Education addresses National priorities and helps teenage parents to cope and succeed, assists homemakers in economically depressed areas, assists the students in applying academic skills in managing home environments, enhances employability skills of youth and adults and assists displaced homemakers as they work. I believe important programs warrant the continuation of line item funding.

Mr Chairman, I commend you and members of this committee for your record of support for Consumer and Homemaking Education. On behalf of the Coalition, I urge that funding for Consumer and Homemaking Education (P.L. 98-524, Title III, Part B) for FY '87 be continued as a line item at the level of $31,633,000. I appreciate the opportunity to express the views of the Coalition regarding Consumer and Homemaking Education.

Mr. NATCHER. Thank you very much, Ms. Ellis. We appreciate your appearance. We want you to know that we appreciate your interest in this program all through the years. Thank you very much.

Ms. ELLIS. Thank you very much.

TUESDAY, APRIL 19, 1986.

CONSUMER AND HOMEMAKING EDUCATION

WITNESS

EVERETT HAMILTON, EXECUTIVE DIRECTOR, AMERICAN HOME ECONOMICS ASSOCIATION

Mr. NATCHER. Our next witness is Mr. Hamilton. Come around, Mr. Hamilton.

Mr. Hamilton, we are glad to have you before the committee. We will be pleased to hear from you.

Mr. HAMILTON. Thank you very much.

Mr. Chairman and Members of the subcommittee, I am Everett Hamilton, and I am 21 years old. I am here to speak on behalf of the American Home Economics Association. It is indeed an honor and a pleasure for me to address you today about a wonderful educational concept; a concept that is preparing young people for the challenges that lie ahead; a concept that is contributing to the stability of the American family; and a concept that is important, but unfortunately, its existence is being threatened like no other time in history. I am talking about consumer and homemaking education, which is part of the Carl D. Perkins Vocational Education Act.

I was a consumer and homemaking education student in Alabama, and am a former State president and national officer of Future Homemakers of America, which is the student organization arm of consumer and homemaking education. I am now a college student at Washington & Lee University in Lexington, Virginia, majoring in journalism. But my ties with consumer and homemaking education and Future Homemakers of America (FHA-HERO) have not ended. I realize that the things I learned on consumer and homemaking education and future homemakers of America will continue to serve me. This has proven true time after time with many of my experiences in college.

The wonderful thing is that my story is not unique. For over 70 years, consumer and homemaking education programs have accepted the awesome task of educating young people with everyday survival skills as well as preparing leaders for the future.

Over 7,000,000 young people have a better understanding of their role in our society because of dedicated personnel in consumer and homemaking education. Take my home economics teacher in Tuskegee, Alabama, who had to listen to some people tell her that her consumer and homemaking education program jeopardized the Federal emphasis on the new movement for excellence and enriched academic curricula. But she kept teaching and believing that she made a difference in her students' lives. Her story is not unique. Consumer and homemaking education teachers all across this great nation are of the same resolve not to just teach cooking and sewing, but home and resource management, budgeting, reinforcing chemistry and mathematics, and a host of other subjects, coupled with leadership, organizational, and problem-solving skills that produce well equipped citizens for this great nation.

The role of the Federal dollar is very important to these teachers and their programs. Without a Federal presence serious harm would come to the development of a new consumer and homemaking education and FHA programs. Imagine a society where young people do not care about healthy bodies and minds, being strong and imaginative, building and carving new frontiers to make this nation great. Imagine families where there is poor communication and management of resources.

Our dream of a strong society will dissipate, for the family is the basic institution of society. Imagine babies being born to mothers not yet independent enough to take care of themselves, and fathers not yet mature enough to realize that they have an obligation to the newborn. I believe this world is a better place, and young people—men and women—are better citizens because of consumer and homemaking education and the future homemakers of America.

Some politicians suffer from the same misconceptions about consumer and homemaking education as those of my fraternity brothers, who, by the way, insist that I am here for a bake-off, or a quilting bee, or to show you how to clean your curtains in this chamber, but I did have an opportunity before I arrived here to tell them some of the terrific things that are going on in classrooms and in chapter meetings, and after about three or four hours they had a pretty good idea about some of the terrific things that are going on, and they were literally shocked.

Very simply, the philosophy of consumer and homemaking education courses is that it is less expensive to teach families to manage resources and to solve problems than it is to pay the social and financial cost of crisis intervention, malnutrition, welfare, et cetera. That successful management of resources in the family contributes to a worker's productivity in the labor market and therefore to the national economic recovery.

Even the nation's defense programs require competent families, able to manage resources and solve problems; and the consumer and homemaking education programs and Future Homemakers of America are the only comprehensive family programs available.

Consumer and homemaking education teachers have mobilized in congressional districts all across the country to save funding for the programs. However, I know they would rather devote all of their energy to teaching and building a solid foundation for young people. I can remember my first home economics class and how I dreaded having to take it. After a few days, I knew that I was going to like the course. The diversity of subjects in that one class parallels many of the subjects that I am now taking in college.

For four years in high school I was guided by consumer and homemaking education and future homemakers of America. Now all I have guiding me down the pathway which will hopefully lead to success is the mosaic of skills and resources that the groups gave me.

The point to all of this, of course, is that the Federal dollars you appropriate for consumer and homemaking education under the Perkins' Act have made a difference in my life, and I am sure in the lives of all of these young people that are in this chamber today. I believe that I speak for millions of others across the country, many in your own Congressional districts.

I would like to thank you for permitting me to address you today. We students and former students of consumer and homemaking education programs appreciate your efforts on our behalf in the past, and we urge you to continue funding these programs at the same level and support them with the same vigor that you have over the past years. Thank you very much.

[The statement of Mr. Hamilton follows:]

PREPARED TESTIMONY
FOR THE
HOUSE
APPROPRIATIONS SUBCOMMITTEE FOR EDUCATION
THE HONORABLE WILLIAM NATCHER, CHAIRMAN

PRESENTED BY
EVERETT HAMILTON
AMERICAN HOME ECONOMICS ASSOCIATION

RAYBURN HOUSE OFFICE BUILDING
ROOM 2358
APRIL 29, 1986
2:15 P.M.

OFFSET
CAMERA COPY

Mr. Chairman and members of the subcommittee: I am Everett Hamilton, and I am 21 years old. I am here to speak on behalf of the American Home Economics Association. It is indeed an honor and a pleasure for me to address you today about a wonderful educational concept; a concept that is preparing young people for the challenges that lie ahead; a concept that is contributing to the stability of the American family; and a concept that is important, but unfortunately, its existence is being threatened. I am talking about Consumer and Homemaking Education, which is part of the Carl D. Perkins Vocational Education Act, PL 98-524, Title III, Part B.

I was a Consumer and Homemaking Education student while in high school and am a former national officer of Future Homemakers of America which is the student organization arm of Consumer and Homemaking Education. I am now a college student at Washington & Lee University in Lexington, Virginia, majoring in Journalism. But, my ties with Consumer and Homemaking Education and Future Homemakers of America (FHA-HERO) have not ended. I realize that the things I learned in Consumer and Homemaking Education and Future Homemakers of America will continue to serve me. This has proven true time after time with many of my experiences in college.

The wonderful thing is that my story is not unique. For over 70 years, Consumer and Homemaking Education programs have accepted the awesome task of educating young people with everyday survival skills as well as preparing leaders for the future.

Over seven million young people have a better understanding of their role in our society because of dedicated personnel in Consumer and Homemaking Education. Take my home economics teacher in Tuskegee, Alabama, who never had enough supply money for basic teaching materials. I am not talking about the "extras," I am talking about a teacher who lived under the threat of having her home economics labs taken away and had to justify her existence. A teacher who ended up catering and hosting every reception that came to my school. A teacher who had to listen to some people tell her that her Consumer and Homemaking Education program jeopardized the Federal emphasis on the new movement for excellence and enriched academic curricula. But, she kept teaching and believing that she made a difference in her students' lives. Her story is not unique. Consumer and Homemaking Education teachers all across the nation are of the same resolve not to just teach cooking and sewing, but home and resource management, budgeting, chemistry, mathematics, and a host of other subjects, coupled with the leadership, organizational, and problem-solving skills that produce well equipped citizens for this great nation.

The role of the Federal dollar is very important to these teachers and their programs. Without a Federal presence, serious harm would come to the development of new Consumer and Homemaking Education and FHA programs. Imagine a society where young people do not care about healthy bodies and minds, being strong and imaginative, following the legacy of our forefathers, building and carving new frontiers to make this nation great. Imagine families where there is poor communication and management of resources. Our dream of a strong society will dissipate, for the family is the basic institutions of society. Imagine babies being born to mothers not yet independent enough to take care of themselves, and fathers not yet mature enough to realize that they have an obligation to the newborn. I believe this world is a better place, and young people—male and female—are better citizens because of Consumer and Homemaking Education and the Future Homemakers of America.

Some politicians suffer from the same misconceptions about Consumer and Homemaking Education as those of my fraternity brothers, who, by the way, insist that I am here for a bake-off, or a quilting bee, or to trade microwave tips. However, I did have an opportunity to set the record straight with my fraternity brothers before I arrived. It is amazing how after I told them some of the terrific things that are being done in the Consumer and Homemaking Education classrooms and Future Homemakers of America chapter meetings, their attitudes changed. My friends were literally shocked.

Eleanor Roosevelt, one of the great women of this century, challenged youth in the early 1930's to get to know their communities, and take on work that may not be as glamorous as marching in parades. Organize first with the knowledge of getting to know yourself, she said, for you have to do this before you can be of help to others. What a challenge to young people!

Mrs. Roosevelt's day was quite different from the one we have today. Drug and alcohol abuse weren't concerns of young people. Teenage pregnancy wasn't a national concern as it is today, so shocking that a recent Time magazine cover was devoted to the issue. Child abuse, stress, suicide, sexuality, and family planning are all major concerns of the public, decision-makers, parents, and teens; concerns that professionals teaching Consumer and Homemaking Education did not wait until 1985 to start addressing. We followed the advice of Mrs. Roosevelt and started to help young people "know themselves."

Of course, there are no easy solutions to all of our problems and concerns, but we also know that if we eliminate our emphasis on Consumer and Homemaking Education, turning our backs on these problems and pretending that they do not exist in our society, in essence we will be turning our backs on an opportunity for better prepared families and a better society. The philosophy of Consumer and Homemaking Education courses is that it is less expensive to teach families to manage resources and solve problems than it is to pay the social and financial costs of crisis intervention, malnutrition, welfare, etc. Successful management of resources in the family contributes to a worker's productivity in the labor market and, therefore, to the national economic recovery. In order to restore further economic health to the nation, skilled workers who can manage scarce resources are essential and vocational education assists in furnishing skilled workers for the nation's labor force. Even the nation's defense programs require competent families, able to manage resources and solve problems; and the Consumer and Homemaking Education programs and Future Homemakers of America are the only comprehensive family program available.

Consumer and Homemaking Education teachers have mobilized in congressional districts all across the country to save funding for the programs. However, I know they would rather devote all of their energy to teaching and building a solid foundation for young people. I can remember my first home economics class and how I dreaded having to take it. After a few days, I knew that I was going to like the course. The diversity of subjects in that one class parallels college. The planning skills I learned fit right in with mapping out my own personal calendar.

When I joined Future Homemakers of America, the Vocational Home Economics Education student organization, I learned how to communicate with people, and how to express the ideas that I had stored away. It was very rewarding to ban together with a nationwide teen movement that wanted to change our society for the better.

For four years in high school I was guided by Consumer and Homemaking Education and Future Homemakers of America. Now, all I have guiding me down the pathway which will hopefully lead to success is the mosaic of skills and resources that the two groups gave me.

The point to all of this, of course, is that the Federal dollars you appropriate for Consumer and Homemaking Education under the Perkin's Act have made a difference in my life. I believe that I speak for millions of others across the country--many within your own Congressional districts. I don't know the details of how Federal dollars are fed to Consumer and Homemaking Education programs, but I do know "what works," and I believe that it is important for you to know "what works" as you consider which programs to fund in these difficult budgetary times.

Thank you for permitting me to address you today. We students and former students of Consumer and Homemaking Education programs appreciate your efforts on our behalf and we urge you to continue funding these programs at the same level and support them with the same vigor that you have over the past few years.

If you have any questions about my experience in Consumer and Homemaking Education programs and the Future Homemakers of America, I would be happy to try to answer them.

Mr. NATCHER. Thank you very much, Mr. Hamilton. You have made an excellent statement.

Mr. HAMILTON. Thank you very much.

TUESDAY, APRIL 29, 1986.

EDUCATION PROGRAMS

WITNESS

PHILLIP E. RUNKEL, SUPERINTENDENT OF PUBLIC INSTRUCTION, STATE OF MICHIGAN, REPRESENTING CHIEF STATE SCHOOL OFFICERS

Mr. NATCHER. Our next witness is Mr. Phillip Runkel. Come around, Mr. Runkel. Mr. Runkel, we are delighted to have you before the committee at this time. Mr. Runkel, I will yield to you.

Mr. PURSELL. I would like to have the honor to introduce our State Superintendent of Education from the State of Michigan who is speaking on behalf of all the States today, Phillip Runkel.

Mr. RUNKEL. Thank you, Congressman Pursell. We would like to thank you for your continued support of education in the Congress. We know you well from your experience in the Michigan legislature and your support there.

Chairman Natcher, I give you greetings from Alice McDonnell. We want to thank you for your continued support, and also your support in the floor fight on many questionable amendments.

I would really like to talk to you about the Federal commitment to education. I speak for all the chiefs throughout the country. I believe it may be stating the obvious to point to you that we understand very clearly that the Congress of the United States has a strong commitment to reduce the Federal deficit. The current plan of the Congress through Gramm-Rudman is to reduce that deficit. From all indications, the Congress is inclined to cut the deficit through both spending reductions and revenue enhancements, and we do not disagree with that aim.

We know very well in Michigan the experience with deficits because it was only a few years ago that we had a deficit of some $900,000,000 and our State was on the brink of bankruptcy. Through revenue enhancement and through sharpening our tools in State government, we were able to overcome that. I hope, however, to clearly illustrate to you today that the Federal educational programs have not contributed to the growth in the deficit and therefore should be cut no further, that the value of Federal programs far exceed the actual appropriations level. Although it is a commonly used axiom, educational spending is an investment in our nation's future.

Federal investment in educational programs actually decreased or is growing at a much smaller rate than the rest of Federal spending, and you will see by looking at Table 1 in the appendix of my testimony, and also according to the Congressional Research Service, funding for education is left far behind inflation by 15.8 percent since 1980. With the exception of Chapter 1, vocational education and education for the handicapped, all Federal programs for elementary and secondary education declined in actual dollars between 1980 and 1986.

Further, while Federal spending grew by 65.9 in the fiscal year 1980 to 1986 period, Federal elementary and secondary programs grew by only 4.2 percent. Fed. spending for elementary and secondary education programs has decreased as a percent of Federal spending as a percentage of Gross National Product in the years between 1980 and 1986. The Federal investment in elementary and secondary education has declined in normal terms, real terms and its relationship to the size of the economy. Federal educational programs, again, have not contributed to the deficit.

I urge this subcommittee, as you begin your deliberations on the 1987 appropriations, to keep in mind the modest nature of educational funding in the past six years.

The Federal Government must continue to play a strong and leading role in the education of our nation's children. Speaking of the modest but more Federal role in education, I would like to clear one misconception concerning State and local financing of elementary and secondary education. Although I am certain that we all agree that the primary responsibility of funding education lies with State and local governments, the State and local governments have increased funding in the 1980s. I believe you will be surprised to know that educational funding in the 1980s, the share has actually declined since 1979.

Secretary Bennett, when pressed about his often confidential support of decreased Federal funding for education, will point to the increase in State and local Federal funding. Since 1979, State and local education funding has increased, but these new funds have not kept pace with inflation in the total national area. Funding for education as a percentage of total expenditures has steadily decreased, as Table 3, Figure 1 of the appendix shows

With enrollments climbing again, spending for elementary and secondary education has decreased as a percentage of total State and local expenditure for education, and as a percentage of total State spending for education. Even more surprising is the fact that all sources of education funding, Federal, State and local have decreased as a percentage of the Gross National Product since 1980.

I want to speak just briefly about a few of the programs that are going to be impacted, and what some of the trends are in those programs. You are, I am sure, familiar with Title I and its success because it has been a successful program. Research points out that it has improved student achievement. Research points out that our students that have gone through the program have done better on SATs, and in Carl Pursell's old district, the High Scope Foundation has found out that preschool education can make a significant difference in terms of the achievement of young people.

Today we have had about a 2.200,000 increase in students since 1980 under Title I, and we are serving 600,000 less in 1985-1986. Forty percent of the eligibles aren't being served. The other issue is obviously that Title I serves the poor children of our country, and many of them are grouped in the cities.

The other issue is many of them are black and Hispanic and we have continued population growth in these areas, and I quote from Harold Hodgkinson, who talks about birth rates in the U.S., when he tells us the 1980 Census reveals the average white in America is 31, the average black is 25, and the average Hispanic only 22. It is easy to see that age produces population momentum for minorities, as a typical Hispanic female moving in the peak childbearing years. Texas schools are 46 percent minority, and half the States have public school populations of more than 25 percent nonwhite, and many of these are in our large city school system. Title I serves those students. It is important that it maintains funding and moves forward to serve the neglected of our country.

Chapter 2, briefly. You know well that this was a consolidation of 28 programs, and it has been an important program for local school districts as well as the State departments of education. Michigan, during the economic decline, faced 150 school districts that were on the verge of bankruptcy. We had school districts that were closing. Without the help of Chapter 2 to provide technical assistance to those districts, our school system may have closed down indirectly.

There are many innovative programs that have also been started by Chapter 2, research programs, our testing program in our State, professional development and teaching programs, and we face a major teaching shortage, school improvement programs, the expansion of technology and leadership development.

We also want to mention the migrant program that serves over 500,000 students, that has reduced dropout rates, and achievement has improved. The magnet school program that serves to help reduce racial isolation and is a new program, competitive grants are established for this program and needs to be maintained.

The second largest Federal program is serving handicapped children. It is an example of how Federal spending has remained with inflation. In 1980, the Federal spending under EHA provided 2 percent of the total spending on education of handicapped children. Federal funding for EHA has remained relatively even with inflation but has declined to about 7 percent of the total spending. The number of students identified will increase and the cost of service has risen faster than inflation.

The Senate will soon consider making services mandatory from birth to age 26, which we have already in Michigan. There may be a tendency to leave the issue of funding of EHA to the Senate. I counsel against this strategy, and urge that this subcommittee provide an inflationary increase for EHA and adequately fund any new mandates.

I have tried to share with you some of the issues that we face across this nation in terms of the Federal role in education. It has been a role that has made a difference for many young people. It has made a difference because we have served many times neglected programs that have not been served by State funding in the past.

It is clear that throughout the nation, as we talk about the Federal deficit, governors are saying that they will not be able to make this money up. I hate to think of our cities and our State and our cities in our nation without Title I, without funding for the handicapped, so it is clear that we want to urge you to consider level funding, as we said earlier. This is a very small part of the Federal budget, and it has contributed practically nothing to the deficit. Thank you very much.

[The statement of Mr. Runkel follows:]

Council of
Chief State
School Officers

STATEMENT REGARDING FY 1987 DEPARTMENT OF EDUCATION APPROPRIATIONS

THE COUNCIL STATEMENT PRESENTED BY

Phillip E. Runkel
Superintendent of Public Instruction
State of Michigan

Before the

Subcommittee on Labor, HHS & Education & Related Agencies

Washington, D.C.
April 29, 1986

Education
...a sound
investment in
AMERICA

Mr. Chairman, My name is Phillip Runkel and I am Superintendent of Public Instruction for the State of Michigan. I am testifying today on behalf of the Council of Chief State School Officers. I'd like to begin my remarks by addressing the issue of the federal commitment to public elementary and secondary education, and the state and local role in funding education. I would also like to bring to the Subcommittee's attention the importance of planning for the future education needs of the United States as illustrated by demographic trends. Finally, I will convey, on behalf of the Council, my funding concerns for some specific federal elementary and secondary education programs.

Although I may be stating the obvious, I believe it is important to point out that we understand that the Congress of the United States has a strong commitment to reducing the federal deficit. The current plan of the Congress, as inspired and required by the Gramm-Rudman-Hollings legislation, is to reduce the deficit. From all indications, the Congress is inclined to cut the deficit through both spending reductions and through revenue enhancement. I do not disagree with the aim of the Congress to reduce the deficit. However, I hope to clearly illustrate to you today that (1) federal education programs have not contributed to the growth of the deficit and therefore should be cut no further and (2) that the value of federal programs far exceeds the actual appropriations levels. Although it is a commonly used axiom, education spending is an investment in our nation's future. Federal investment in education programs has actually decreased or grown at a much smaller rate than the rest of federal spending as Table I in the Appendix of my testimony shows. And, according to the Congressional Research Service, funding for education has lagged far behind inflation by 15.8% since FY 1980. With the exception of Chapter 1, Vocational Education, and Education for the Handicapped, all federal programs for elementary and secondary education declined in actual dollars between FY 1980 and FY 1986. Further, while all federal spending grew by 65.9% in the FY 1980-86 period, federal elementary and secondary education programs grew by only 4.2%. (Table II of the Appendix)

Federal spending for elementary and secondary education programs has decreased as a percentage of federal spending and as a percentage of Gross National Product (GNP) in the years between FY 1980 and FY 1986. As Table I of the Appendix of this testimony indicates, in FY 1980, federal support for elementary and secondary education constituted 1.17% of total outlays. In FY 1986, the percentage dropped to .69%. In FY 1980, federal funding of elementary and secondary programs was .26% of the GNP; in FY 1986, it constitutes only .15%. The federal investment in elementary and secondary education has declined in nominal terms, real terms, and in relationship to the size of the ecomony. Federal education programs, however, have not contributed to the growth of the deficit and should not be reduced. I urge this Subcommittee, as you begin your deliberations on the FY 1987 appropriations, to keep in mind the modest nature of education funding in the past six years.

The federal government must continue to play a strong and leading role in the education of our nation's children.

Speaking of the modest, but important federal role in education, I would like to clear up a misconception concerning state and local financing of elementary and secondary education. Although I am certain that we all agree that the primary responsibility of funding elementary and secondary education lies with state and local governments and that state and local governments have increased education funding in the 1980's, I believe that you will be surprised to learn that education's share of state and local expenditures has actually declined since 1979. Secretary of Education William J. Bennett, when pressed about his often controversial support of decreased federal funding of education, will point to the increase in state and local funding. Although since 1979 state and local education funding has increased, those new funds have not kept pace with inflation in the total national aggregate. Funding for education as a percentage of total state expenditures has steadily decreased as Table III and Figure I in the Appendix shows. More importantly, with school enrollments climbing again, spending for elementary and secondary education has decreased as a percentage of total state and local expenditures for education and as a percentage of total state spending for education. Even more surprising is the fact that all sources of education funding--federal, state, and local--have decreased as a percentage of the Gross National Product since 1980. (Table III and Figure II) Thus, investment in education is down in relation to the total economy, a condition that cannot continue if this country is to remain a functioning democracy and an economic leader.

One explanation for the decline of education as a share of total state, local, and federal expenditures concerns the decline in funding from federal sources which led to more competition among domestic programs at the state level for scarce dollars. Although education is a priority for most states, because of the need to cover some federal program cuts, the actual financing of education by state and local entities is declining. In this atmosphere, federal money becomes even more valuable.

As federal, state, and local funding sources for elementary and secondary education are decreasing, the number of students enrolled in public schools is increasing, thereby stretching the available pool of funds even further. According to a 1983 report, which was sponsored by the American Council on Education, the Forum of Educational Organization Leaders, and the Institute for Educational Leadership entitled "Demographic Imperatives: Implications for Educational Policy", the new baby boom is reversing the decline in school enrollment which was witnessed in the 1960's and 1970's. The report suggests that minorities are the fastest growing portion of our population and that Hispanics are the fastest growing minority group. The simple fact of an expanding minority enrollment is not in itself troublesome. However, the continuing high correlation between race and ethnicity and poverty means that much of the enrollment in schools is comprised of economically disadvantaged children. Generally, economically disadvantaged children are less prepared for school than are economically advantaged children.

Economically disadvantaged children can do as well in school as other children, as we have demonstrated in Head Start, Chapter 1, and our Michigan Effective Schools program.

As the make-up of the public school enrollment becomes less homogenous, schools will be faced with new challenges in delivering educational services. Data indicate that blacks and Hispanics lag far behind the white American in education. For example, in 1980, 83% of all whites age 18 to 24 were high school graduates as compared to 54% high school graduation rate among Hispanics age 18 to 24. According to the report, 21% of all black high school students drop out of high school. At the same time, college enrollment for blacks and Hispanics declined in the years between 1974 and 1980. The report states, "It will be up to educators, civic leaders, and policy makers to respond to these emerging realities in ways that promote equality, strenthen the economy, and sustain an adaquate national defense." I suggest that Congress, as well as state and local education agencies, must examine the implications of demographic shifts and take steps to ensure that the educational services, which this growing population requires can be delivered in an effective and efficient manner. In a nutshell, we all must begin to plan for the educational future of the United States. This Subcommittee can take steps toward this future by funding federal education programs at an adequate level.

Every federal education program provides some sort of a special assistance to the state or local education agency which receives it.

Although I could easily take up the Subcommittee's time with success stories for all federal programs and how they have made a difference in my job as Superintendent of Public Instruction for the State of Michigan, I would like to only highlight funding needs for a few of the programs.

To begin, Chapter 1, the largest federal elementary and secondary education program, provides financial assistance to school districts for compensatory education services, and to SEAs for migrant, handicapped, and neglected and delinquent children. Chapter 1 has proven to be a very effective program. A U.S. Department of Education study shows that low-achieving students who participate in Chapter 1 do significantly better in school than do their counterparts who do not participate in Chapter 1. Data from the Educational Testing Service (which produces the SAT) and the National Assessment of Education Progress (NAEP) indicate that the rise in SAT scores and other education achievment indicators contained in the Department of Education's Wall Chart are clearly related to the compensatory education services provided by the Chapter 1 program. In the future, Chapter 1 will play an even more important role in addressing some of the needs posed by the demographic trends of the United States.

The Migrant Education program of Chapter 1 is particularly important to the State of Michigan and the 23,795 students who receive services in my state annually. This program provides funds through SEAs and LEAs to assist in meeting the special education needs nationally of about 500,000 children of migratory fishers and agricultural workers.

Activities supported by this program include supplementary educational programs during the regular school year and summer months in many school districts which receive too little in Chapter 1 basic grants to meet the needs of migrant students. The success of this program can be found in the declining drop out rate for migrant students. Other important activities include inter and intra state coordination which enable a migrant student to complete his or her high school education by bridging the various curriculum offerings and requirements faced by moblie students. Under the President's budget, unfortunately, migrant education is the only state-operated Chapter 1 program recommended for a cut. I strongly urge you to reject this short-sighted proposal.

The Chapter 1 program has received only modest increases in funding since FY 1980. Although the number of disadvantaged children has increased by 2.2 million since 1980, only 40% of the eligible Chapter 1 children are currently being served. Further, because funding has not kept pace with inflation, approximately 600,000 fewer students are being served by Chapter 1 in the 1985-86 school year than were being served in 1980-81. It is important, then, that Chapter 1 remain funded at least at the FY 1986 level.

The other half of the Education Consolidation and Improvement Act (ECIA), Chapter 2, enables states and localities to implement a variety of program improvements which best suit their needs. Funds may be used for any of the authorized purposes of the 28 programs which were consolidated into Chapter 2, or any other supplementary education improvement, research, teacher training, and instructional support deemed appropriate by an LEA. As state funds have become more scarce, Chapter 2 has enabled SEAs and LEAs to launch programs which address specific needs. Without this money, many states and local school districts would be unable to attempt new and innovative educational projects. Funding for Chapter 2 has decreased by approximately 20% in nominal terms since FY 1980.

The second largest federal program serving handicapped children, Education of the Handicapped (EHA), is an example of how federal spending can remain even with inflation and yet decline relative to state and local spending. In FY 1980, federal spending under EHA, provided 12% of the total spent on education of handicapped children. Federal funding for EHA has remained relatively even with inflation (according to the Congressional Research Service), but has declined to about 7% of total spending. The number of students identified has increased with increasing enrollment, and the cost of services has risen faster than inflation. The Senate will soon consider making services mandatory from birth which will increase the cost of services beyond the expected increases in enrollment. There may be a tendency to leave the issue of adequate funding of EHA to the Senate. I counsel against that strategy and urge that this Subcommittee provide an inflationary increase for EHA and adequately fund any new mandates. The data from Table II shows that states and LEAs are not increasing funding enough to cover further federal short falls or unfunded mandates. Forcing local or state governments to choose between handicapped and non-handicapped students is a long range recipe for disaster and counter to the American values concerning equal educational opportunity.

The Women's Educational Equity Act (WEEA), helps to remedy discrimination against women and girls in our nation's educational system. Grants and contracts are awarded each year for the development, demonstration, and dissemination of model educational equity projects and programs of national, statewide, or general significance. WEEA was funded from FY 1982 to FY 1984 at $5.76 million and in FY 1985 and 1986 at $6 million. WEEA is a worth-while program and should be funded at a level which maintains current service levels

Under Title IV of the Civil Rights Act of 1964, states receive assistance to strengthen the capacity of the SEA to provide appropriately targeted training and technical assistance to LEA staff. Enhanced leadership at the state level is a critical component of any effective strategy to promote the achievement of equitable educational opportunity. Title IV supports activities, such as racial desegregation centers, which promote voluntary compliance by SEAs and LEAs with civil rights laws. Title IV, then, ultimately benefits all students by enhancing the capabilities of SEA and LEA personnel. The program has been level funded at $24 million since FY 1982. Further cuts would seriously jeopardize the entire program and further weaken support for educational opportunities in public schools. Title IV is the only targeted federal assistance available to SEAs for aid on desegregation issues.

The Magnet Schools program is another relatively small federal education activity which will become increasingly important as the demographics of the United States change. The purpose of the Magnet Schools' program is to provide financial assistance to eligible LEAs to eliminate, reduce, or prevent minority isolation and to improve academic instruction and vocational training. The Magnet Schools program is the only direct aid to LEAs which is designed to eliminate segregation, and thus remains important as a statement of public policy, as well as sound educational practice. Because the Magnet Schools program is new, schools which receive competitive grants are just now using their money. Numerous studies indicate that the magnet schools are effective in voluntarily desegregating local school systems.

The Leadership in Educational Administration Development (LEAD) program provides at least $150,000 per state for the development of administrative training institutes. These centers will provide technical assistance and pratical training to new and mid-career administrators, enabling them to become more effective educational leaders. Many studies have shown that effective administration of the nation's schools is a key component in the quality of a school. While some larger states have initiated Administrative Leadership programs previous to the enactment of this legislation, many small states have had difficulty in doing so. The LEAD legislation ensures that all states can improve and enhance the quality of their local educational leaders. The LEAD program received its first appropriation in FY 1986.

Finally, I would like to discuss the importance of the federal student financial assistance programs. Often, it is the loan or grant from the federal government which makes a difference in a student having access to a college education. Programs such as Pell Grants, National Direct Student Loans, and Guaranteed Student Loans ensure that all segments of the population have an opportunity for education beyond the secondary level. Too often student aid programs have been the target of the budget axe. This has had a chilling effect on students even attempting to seek out resources to further their education. I am hopeful the Subcommittee will continue its historical support of student aid programs and turn back the current attempts to curtail the federal governments' most critical investment in higher education.

In closing, I would like to summarize the main points of my testimony. First, federal support for elementary and secondary education has declined in real and nominal terms since 1980. Second, the relative share of total state and local expenditures dedicated to elementary and secondary education has declined since 1979. Third, demographic shifts indicate that new and increased demands will be made on our nation's schools to meet the changing educational needs of our country. Finally, federal education programs provide needed leadership and funding which work towards the improvment of education. I urge members of this Subcommittee to take these four points into consideration as you begin the appropriations process.

APPENDIX

Table I

OUTLAYS FOR ELEMENTARY AND SECONDARY EDUCATION AS A PERCENTAGE OF TOTAL FEDERAL OUTLAYS AND GNP

($ in millions)

FISCAL YEAR	ELEM/SEC FUNDING	TOTAL OUTLAYS	PERCENT OF TOTAL OUTLAYS	GNP	PERCENT OF TOTAL GNP
1980	6.9	590.9	1.17%	2,667.6	0.26%
1981	7.2	678.2	1.06%	2,986.2	0.24%
1982	6.8	745.7	0.91%	3,141.5	0.22%
1983	6.3	808.3	0.78%	3,320.9	0.19%
1984	6.5	851.8	0.76%	3,695.3	0.18%
1985	7.6	946.3	0.80%	3,936.8	0.19%
1986(est)	7.4	979.0	0.76%	4,274.0	0.17%

SOURCE:

Executive Office of the President. Office of Management and Budget. Budget of the United States Government Fiscal Year 1986. Washington: Government Printing Office, 1985.

TABLE II

Budget Authority for Federal Elementary and Secondary Education Programs FY'80 to Proposed FY'87
($ in millions)

Program	FY'80	FY'81	FY'82	FY'83	FY'84	FY'85	GRH FY'86	Change
Chapter 1	3.222	3.111	3.039	3.200	3.487	3.688	3.529	+9.52%
Chapter 2	867	614	586	534	527	758	674	-22.27%
PL 94-142	1.049	1.025	1.068	1.199	1.239	1.321	1.349	+28.59%
Impact Aid	775	682	456	540	585	695	662	-14.59%
Voc Ed	779	681	656	728	738	842	813	+4.36%
Bilingual	166	161	138	138	139	139	133	-19.88%
Indian Ed	76	82	78	69	69	67	64	-15.79%
Adult Ed	123	100	86	95	100	102	96	-21.96%
Immigrant	-0-	-0-	-0-	-0-	30	30	29	-0-
TOTAL	7.056	6.457	6.109	6.505	6.916	7.643	7.353	+4.2%

SOURCE:

Executive Office of the President. Office of Management and Budget. Budget of the United States Government Fiscal Year 1986. Washington: Government Printing Office, 1985.

TABLE III
STATE & LOCAL EXPENDITURES FOR EDUCATION
(in millions of $)

	FY 1979	FY 1980	FY 1981	FY 1982	FY 1983	FY 1984
TOTAL STATE & LOCAL EXPENDITURES [2]	381,867.1	434,073.4	487,048.0	522,760.0	566,567.0	600,576.0
TOTAL STATE & LOCAL EDUCATION EXPENDITURES [2]	119,448.2	133,210.8	145,784.3	154,573.2	163,875.7	176,107.6
ELEM./SEC. [2]	83,385.2	92,930.9	100,534.5	106,101.2	112,945.2	120,895.7
POST-SEC. [2]	30,058.9	33,919.3	38,114.3	41,520.9	43,820.1	47,612.9
OTHER [2]	6,004.2	6,361.5	7,135,5	6,951.1	7,110.4	7,599.0
% STATE & LOCAL EXPENDITURES FOR EDUCATION	31.26%	30.65%	29.93%	29.56%	28.92%	29.32%
ELEM./SEC.	21.83%	21.41%	20.64%	20.29%	19.93%	20.13%
POST-SEC.	7.87%	7.81%	7.82%	7.94%	7.73%	7.92%
OTHER	1.57%	1.46%	1.46%	1.32%	1.25%	1.26%
% OF STATE & LOCAL EDUCATION EXPENDITURES FOR EDUCATION	69.80%	69.76%	68.96%	68.64%	68.92%	68.64%

TOTAL EXPENDITURES FOR ELEMENTARY & SECONDARY EDUCATION
(in millions of $)

	FY 1980	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986
STATE EXPEND. FOR ELEM/SEC.	92,930.9 [2]	100,534.5 [2]	106,101.2 [2]	112,946.2 [2]	120,895.7 [2]	125,094.2 [3]	134,604.9 [4]
FEDERAL EXPEND. FOR ELEM/SEC.	7,056.0 [1]	6,457.0 [1]	6,109.0 [1]	6,508.0 [1]	6,916.0 [1]	7,643.0 [1]	7,383.0 [1]
TOTAL	99,986.9	106,991.5	112,210.2	119,460.2	127,811.7	132,737.2	141,987.9

TOTAL EXPENDITURES FOR ELEMENTARY & SECONDARY EDUCATION AS A PERCENTAGE OF GROSS NATIONAL PRODUCT

	FY 1980	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986
% of GNP	3.74%	3.58%	3.57%	3.59%	3.45%	3.37%	3.32%

SOURCE:

1. Executive Office of the President. Office of Management and Budget. Budget of the United States Government Fiscal Year 1986. Washington: Government Printing Office, 1985.

2. U.S. Department of Commerce. Bureau of the Census. Governmental Finances in 1978-79. Washington: Goverment Printing Office, 1980.

________________________. Governmental Finances in 1979-1980. Washington: GPO, 1981.

________________________. Governmental Finances in 1980-81. Washington: GPO, 1982.

________________________. Governmental Finances in 1981-82. Washington: GPO, 1983.

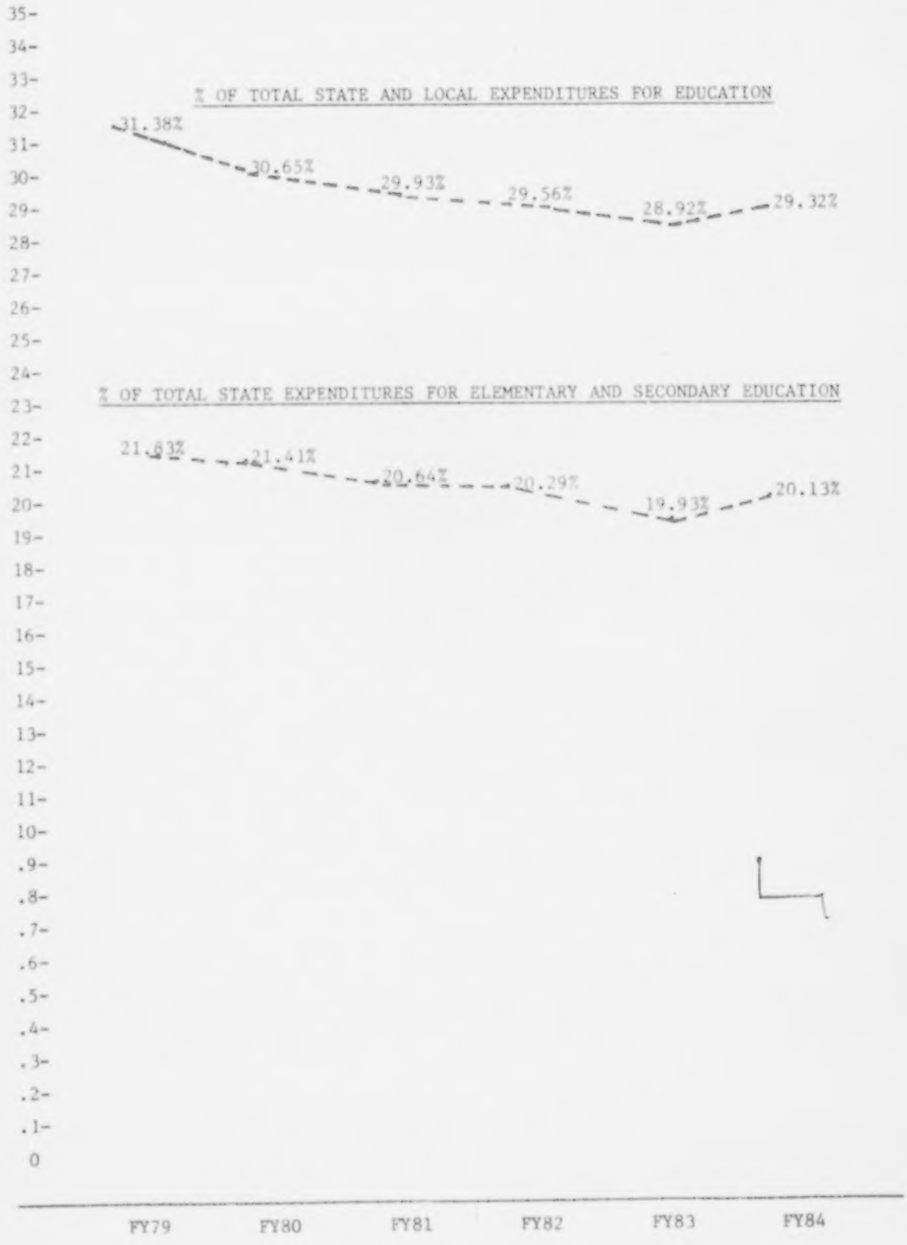
________________________. Governmental Finances in 1982-83. Washington: GPO, 1984.

________________________. Governmental Finances in 1983-84. Washington: GPO, 1985.

3. National Education Association. Estimates of School Statistics 1984-85. Washington: National Education Association, 1985.

4. National Education Association. Estimates of School Statistics 1985-86. Washington: National Education Association, 1986.

Figure 1


% OF TOTAL STATE AND LOCAL EXPENDITURES FOR EDUCATION
31.38%
30.65%
29.93%
29.56%
28.92%
29.32%
% OF TOTAL STATE EXPENDITURES FOR ELEMENTARY AND SECONDARY EDUCATION
21.63%
21.41%
20.64%
20.29%
19.93%
20.13%
35-
34-
33-
32-
31-
30-
29-
28-
27-
26-
25-
24-
23-
22-
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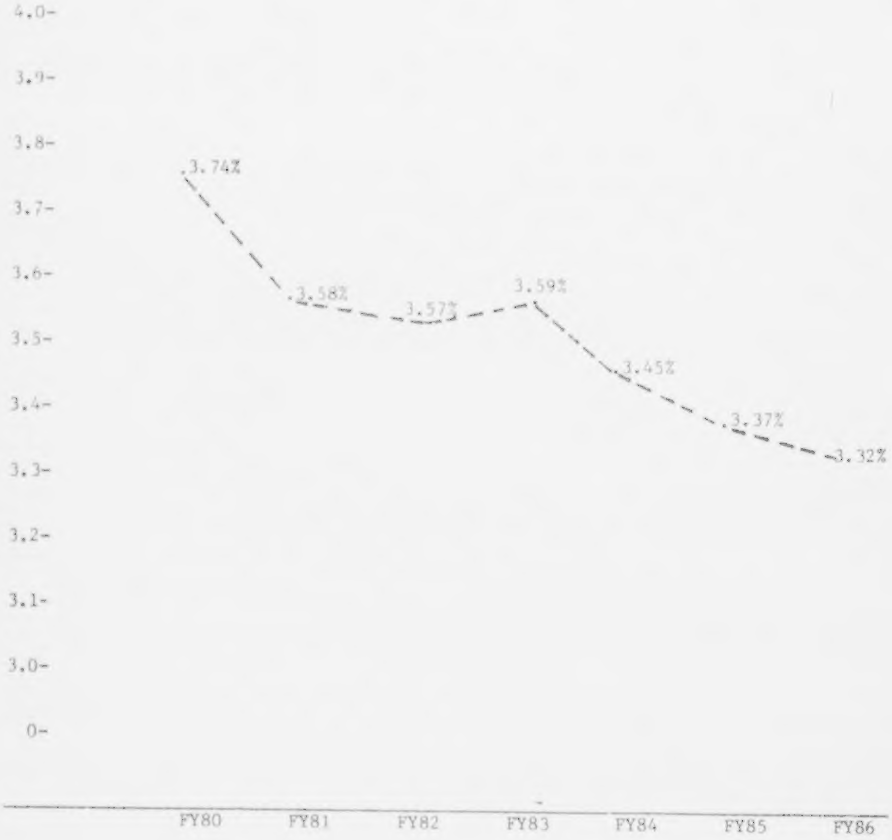
.9-
.8-
.7-
.6-
.5-
.4-
.3-
.2-
.1-
0
FY79
FY80
FY81
FY82
FY83
FY84

Figure 2

TOTAL FEDERAL, STATE AND LOCAL EXPENDITURES
FOR ELEMENTARY AND SECONDARY EDUCATION
AS A % OF GNP



Mr. NATCHER. Thank you, Mr. Runkel. You have given us an excellent statement and we appreciate your appearance.

TUESDAY, APRIL 29, 1986.

EDUCATION PROGRAMS

WITNESS

HOWARD D. MEHLINGER, DEAN, SCHOOL OF EDUCATION, INDIANA UNIVERSITY, BLOOMINGTON, INDIANA

Mr. NATCHER. Our next witness is Mr. Howard Mehlinger.

We have our friend and colleague, John Myers of Indiana, one of the able Members of our full committee to introduce Dr. Mehlinger.

Mr. MYERS. Thank you, Mr. Conte, and Mr. Chairman. May I reflect just a moment. I remember 45 years ago I tried to get into a home ec class back in high school. They hired a very attractive high school teacher, and I requested to get in and they wouldn't let me. So I married her. I have been learning ever since.

Well, Mr. Chairman, Members of the committee, the next witness is no stranger to this committee, and has been a good friend of mine for a number of years. He served in the public school system in Pittsburgh, been on the faculty of Northwestern University, and he has been a professor of education and history. He is highly regarded in Indiana as an authority on education, what is needed in our education. And you are hearing many witnesses in this area but it is a pleasure to present a former constituent. He got rid of me a few years ago, but Howard Mehlinger is Dean of the School of Education at Indiana University.

Mr. MEHLINGER. Thank you very much.

A few years ago I was invited to appear to share some ideas about things that might be done to improve elementary and secondary education in American schools. In subsequent years I have come before you to talk about a program under way at Indiana University, the Center for Excellence in Education, a development program.

I wish to begin by thanking this committee for the extraordinary consideration and support that you have provided through the Congress to the Center for Excellence in Education at Indiana University. Without your review and your willingness to consider supporting this unique center, it is highly unlikely that we could have made anywhere near the progress we made. I want to thank John Myers for his support. He has been a helper throughout our effort to build this program, and I am grateful to all of his attention to it.

My reason for coming before the committee this afternoon is twofold: to give you a progress report on what has occurred in the last few months, partly as a result of the initiative you helped support, and secondly, I want to ask you and your committee, Mr. Chairman, for continuing support in fiscal year 1987 so we can complete our effort. Briefly, let me talk about three things that have occurred: The financing from the Federal Government and the State of Indiana, the progress we have made on the private fundraising from corporations and foundations and the actual development of the facility.

You will recall in fiscal year 1986 Labor, Health and Human Services and Education Appropriations Bill, this committee appropriated $6,000,000 pursuant to an authorization passed by the Congress for Federal support of the Center for Excellence in Education.

I would like this committee to know how important that major step by you and your colleagues has been to our effort. As you know, when we first testified about our aspirations and dreams for the Center for Excellence, we had developed a program whose total cost was estimated to be $42.3 million.

Towards that goal, we have been seeking $10 million from the Federal Government and more than $30 million from the private sector, the university community—its friends and alumni—and the State of Indiana. Your appropriation of $6,000,000, the first fed. investment in this Center, has become a genuine cornerstone for attracting private sector funds. For that, we are very grateful.

We have begun discussions with the Department of Education for the purpose of drawing down the first $6,000,000 you have appropriated. As you know, however, President Reagan has proposed a rescission of these funds. I hope that this committee will stand by its earlier decision and not accept the President's proposed rescission. Once the 45 days of the rescission period have expired, we will be able to conclude an agreement with the Department of Education and begin work on the Center.

Governor Robert D. Orr is a strong supporter of the Center and helped launch our effort. We have notified Governor Orr of the Federal appropriation, and he is fully aware of the need for matching funds. At one time we thought the Center would likely be housed in a remodeled facility on the Bloomington campus, but President Ryan has now decided that the requirements of the Center call for an entirely new building. A request for a new building is being added to the University's capital request to the Indiana General Assembly.

Although I am offering this testimony six to eight weeks before its formal announcement, I cannot refrain from sharing recent good news with this committee. Only last week I learned that the AT&T Corporation has accepted our invitation to join us as a corporate partner in the Center for Excellence in Education. While the total amount of the contribution has not been determined, it is likely to range between $5,000,000 and $6,000,000. There is no doubt in my mind that the confidence exhibited in us by Congress was an enormous incentive in helping AT&T reach its decision.

They indicated to me that they will help make the Center for Excellence in Education at Indiana University a showplace for the nation, an exhibit of what can be done when private enterprise, government—Federal and State—a major university, and the schools join in common cause to assist in the reform and improvement of American education.

I can report other progress from the private sector: two grants from the GTE Foundation enabling us to award almost $60,000 in undergraduate scholarships for science and math teachers, a $250,000 grant from the Burroughs Corporation to train school administrators in the use of modern data processing techniques, a grant of $100,000 from the Cummins Engine Foundation to improve writing skills of students in Indiana, and a grant for $170,000 from the Lilly Endowment to create a consortium for policy studies in education to assist State-level policymakers in planning the future of education in Indiana.

We have identified the site for the new building and are in the process of selecting architects to design the new facility. We fully expect that an architect will be named at the June meeting of the Indiana University Board of Trustees. The AT&T Corporation has named a project manager to work with us at every stage to help plan the technology that will go into the building. I may be too optimistic, but I remain hopeful that actual construction can begin before the end of this year.

Meanwhile, we are working aggressively on specific Center programs. While I speak, a major corporation that must remain unidentified this afternoon is considering a proposal calling for a partnership involving the State Department of Education, a select number of Indiana school corporations, Indiana University, and a computer corporation that, together, will invest more than $3,000,000 over a five-year period to test ways to enhance teacher productivity through the appropriate use of computer technology.

Indiana University and 12 Indiana school corporations will soon be joining a national network of school-university partnerships engaged in resolving some of the most difficult problems affecting working conditions in schools. The national network is supported by the Exxon Foundation and the Danforth Foundation.

In the last month we have joined with others in establishing a Principals' Assessment Center that will aid in the recruitment and selection of able people into leadership positions in Indiana schools. These are but a few of the programs underway. They are cited merely to inform you that as important as a new facility will be, we are not waiting until the facility is in place to work on needed tasks.

Mr. Chairman and Members of the committee, as I mentioned, I do wish to ask ~~for~~ your continued support for the Center for Excellence in fiscal year 1987. Our goal is to complete our efforts to raise the necessary funds to build and equip the Center during fiscal year 1987 and fiscal year 1988.

When we first approached the Congress, and in particular this committee, we presented to you a proposed package totaling $42,300,000, of which we were seeking $10,000,000 in Federal support. It is with considerable appreciation that I ask you to consider providing the final $4,000,000 in Federal funds that we were originally seeking.

We are asking Congress to consider authorizing and appropriating those funds during fiscal year 1987 because we find ourselves in the positive position of achieving considerable private sector and State support for this Center.

Naturally, we are very willing to participate fully in any "Gramm-Rudman-Hollings" type cuts and reductions this committee deems appropriate.

As I explained earlier, we have not been able to draw upon the first $6,000,000 until the deadline for the President's rescission has passed. With the selection of the architect in June, design and construction will move forward at a rapid pace. An appropriation of $4,000,000 during fiscal year 1987 will ensure no delays in construction and enable us to complete the project on schedule.

Governor Orr has been a strong supporter of this program.

In summary, allow me to reiterate our appreciation to this committee for all of your support and for your faith in our efforts. All of us involved with the Center for Excellence look forward to the day when we can invite you to visit this model Center so that you can evaluate firsthand the success that you have made possible through this Federal private, State, and university partnership.

Thank you very much.

[The statement of Mr. Mehlinger follows:]

"EXCELLENCE IN EDUCATION"

TESTIMONY PRESENTED

TO

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON LABOR, HEALTH, HUMAN SERVICES
AND RELATED AGENCIES

WILLIAM NATCHER, CHAIRMAN

BY

HOWARD D. MEHLINGER
DEAN, SCHOOL OF EDUCATION
INDIANA UNIVERSITY
BLOOMINGTON, INDIANA

APRIL 29, 1986

INTRODUCTION

Mr. Chairman and Members of the Committee: I am Howard D. Mehlinger, Dean of the School of Education and Professor of Education and History at Indiana University. I wish to thank the Committee for this opportunity to appear before you this afternoon. Three years ago, I was invited to testify before this Committee to share some of my ideas regarding the most effective ways in which the Federal Government might contribute to the reform of elementary and secondary schooling in the United States. During the past two years, my colleague, Tom Schreck, and I have come before this Committee to report on very specific efforts underway at Indiana University to create a Center for Excellence in Education.

I wish to begin by thanking this Committee for the extraordinary consideration and support that you have provided through the Congress of the United States to the Center for Excellence in Education at Indiana University. Without your review of our program and without your willingness to consider supporting this unique Center, it is highly unlikely that our efforts could have succeeded.

I also wish to thank Congressman John Myers for his leadership and support. He has worked closely with us, supporting our plans, while challenging us to do the best job we can. In addition, I wish to express my thanks to

Congressman Lee Hamilton for all of his efforts and his confidence in our capabilities.

I am here today to report that while we are only at the early stages of designing the building and equipping the Center for Excellence, we have made substantial progress in achieving necessary support from both the public and private sectors for this model Center.

My purpose this afternoon is two-fold. First, I wish to give this Committee a progress report on the efforts we are making at the Center for Excellence in Education in three areas:

a) public financing from the Federal Government and the State of Indiana;

b) private fundraising from corporations and foundations; and

c) the actual development of the facility and programs for the Center for Excellence in Education.

Second, I wish to ask you and your Committee, Mr. Chairman, for continued support in FY '87 so that we can complete this model Center.

BACKGROUND ON CONGRESSIONAL ACTION

In the Fiscal 1986 Labor, Health and Human Services and Education Appropriations bill, this Committee appropriated

$6 million pursuant to an authorization passed by the Congress for federal support of the Center for Excellence in Education.

I would like this Committee to know how important that major step by you and your colleagues has been to our effort. As you know, when we first testified about our aspirations and dreams for the Center for Excellence, we had developed a program whose total cost was estimated to be $42.3 million. Towards that goal, we have been seeking $10 million from the Federal Government and more than $30 million from the private sector, the University community (its friends and alumni), and the State of Indiana. Your appropriation of $6 million, the first federal investment in this Center, has become a genuine cornerstone for attracting private sector funds. For that, we are very grateful.

PUBLIC FINANCING

We have begun discussions with the Department of Education for the purpose of drawing down the first $6 million you have appropriated. As you know, however, President Reagan has proposed a recission of these funds. I hope that this Committee will stand by its earlier decision and not accept the President's proposed recission. Once the 45 days of the recission period have expired, we will be able to conclude an agreement with the Department of Education and begin work on the Center.

Governor Robert D. Orr is a strong supporter of the Center and helped launch our effort. We have notified Governor Orr of the federal appropriation, and he is fully aware of the need for matching funds. At one time we thought the Center would likely be housed in a remodeled facility on the Bloomington campus, but President Ryan has now decided that the requirements of the Center call for an entirely new building. A request for a new building is being added to the University's capital request to the Indiana General Assembly.

PRIVATE FUNDRIASING FROM CORPORATIONS AND FOUNDATIONS

Although I am offering this testimony six to eight weeks before its formal announcement, I cannot refrain from sharing recent good news with this Committee. Only last week I learned that the AT&T Corporation has accepted our invitation to join us as a corporate partner in the Center for Excellence in Education. While the total amount of the contribution has not been determined, it is likely to range between $5 and $6 million. There is no doubt in my mind that the confidence exhibited in us by Congress was an enormous incentive in helping AT&T reach its decision. They indicated to me that they will help make the Center for Excellence in Education at Indiana University a showplace for the nation, an exhibit of what can be done when private enterprise, government (federal and state), a major university, and the schools join in common cause to assist in the reform and improvement of American education.

I can report other progress from the private sector: two grants from the GTE Foundation enabling us to award almost $60,000 in undergraduate scholarships for science and math teachers, a $250,000 grant from the Burroughs Corporation to train school administrators in the use of modern data processing techniques, a grant of $100,000 from the Cummins Engine Foundation to improve writing skills of students in Indiana, and a grant for $170,000 from the Lilly Endowment to create a consortium for policy studies in education to assist state level policy-makers in planning the future of education in Indiana.

THE CENTER FOR EXCELLENCE IN EDUCATION

We have identified the site for the new building and are in the process of selecting architects to design the new facility. We fully expect that an architect will be named at the June meeting of the Indiana University Board of Trustees. The AT&T Corporation has named a project manager to work with us at every stage to help plan the technology that will go into the building. I may be too optimistic, but I remain hopeful that actual construction can begin before the end of this year.

Meanwhile, we are working aggressively on specific Center programs. While I speak, a major corporation that must remain unidentified this afternoon is considering a proposal calling for a partnership involving the State Department of Education, a select number of Indiana school corporations, Indiana University, and a computer corporation that, together, will invest more than $3 million over a five year period to test ways to enhance teacher productivity through the appropriate use of computer technology. And Indiana University and 12 Indiana school corporations will soon be joining a national network of school-university partnerships engaged in resolving some of the most difficult problems affecting working conditions in schools. The national network is supported by the Exxon Foundation and the Danforth Foundation. In the last month we have joined with others in establishing a Principals' Assessment Center that will aid in the recruitment and selection of able people into leadership positions in Indiana schools. These are but a few of the programs underway. They are cited merely to inform you that as important as a new facility will be, we are not waiting until the facility is in place to work on needed tasks.

FUTURE FEDERAL SUPPORT

Mr. Chairman and Members of the Committee, as I mentioned, I do wish to ask for your continued support for the Center for Excellence in Fiscal 1987. Our goal is to complete our efforts to raise the necessary funds to build and equip the Center during Fiscal 1987 and Fiscal 1988.

When we first approached the Congress, and in particular this Committee, we presented to you a proposed package totaling $42.3 million, of which we were seeking $10 million in federal support. It is with considerable appreciation that I ask you to consider providing the final $4 million in federal funds that we were originally seeking. We are asking Congress to consider authorizing and appropriating those funds during Fiscal 1987 because we find ourselves in the positive position of achieving considerable private sector and State support for this Center.

Naturally, we are very willing to particpate fully in any "Gramm-Rudman-Hollings" type cuts and reductions this Committee deems appropriate.

As I explained earlier, we have not been able to draw upon the first $6 million until the deadline for the President's recission has passed. With the selection of the architect in June, design and construction will move forward at a rapid pace. An appropriation of $4 million during Fiscal 1987 will ensure no delays in construction and enable us to complete the project on schedule.

SUMMARY

In summary, allow me to reiterate our appreciation to this Committee for all of your support and for your faith in our efforts. All of us involved with the Center for Excellence look forward to the day when we can invite you to visit this model Center so that you can evaluate firsthand the success that you have made possible through this federal, private, state, and university partnership.

Thank you very much.

# # #

Mr. **Natcher**. Thank you very much. We appreciate your appearance.

Mr. **Conte**. Doctor, that rescission is lapsing on the 16th, so you ought to be able to collect that money right now.

Mr. **Mehlinger**. I appreciate hearing that, Mr. Conte.

Someone had spoken to us orally about that but we have not seen anything in writing about it, and so frankly was uncertain as to whether that rescission had now expired or not.

Mr. **Conte**. It was not approved by this Committee.

Mr. **Mehlinger**. Thank you very much.

Mr. **Natcher**. Thank you very much.

Tuesday, April 29, 1986.

VOCATIONAL EDUCATION

WITNESS

ROSEMARY KOLDE, ASSOCIATE SUPERINTENDENT OF GREAT OAKS JOINT VOCATIONAL SCHOOL DISTRICT, CINCINNATI, OHIO, AND PRESIDENT, AMERICAN VOCATIONAL ASSOCIATION

Mr. **Natcher**. Our next witness is Ms. Rosemary Kolde.

Ms. **Kolde**. Thank you very much.

I am Rosemary Kolde, Associate Superintendent of Great Oaks Joint Vocational School District in Cincinnati, Ohio, and President of the American Vocational Association. I would like to bring personal thanks to Congressman Stokes, and I am happy to see him here today.

AVA is the primary professional association for 50,000 vocational educators who provide vocational education and job training in every community in the nation.

As a native of Kentucky, transplanted to Ohio, it gives me great pleasure to have the opportunity today to appear before your subcommittee. I am currently serving as a consultant on vocational education with the Louisville school system and have worked with your State leadership in vocational education. I am quite familiar with vocational education as it exists in the State of Kentucky.

Today I would like to make recommendations for fiscal 1987 appropriations for vocational education.

Vocational education affects the livelihood of 19,500,000 vocational students in every community of this nation.

It is the primary system that provides the necessary bridge between school and the workplace.

Vocational education has historically been funded by a strong Federal, State and local partnership.

The Federal dollar, driven by the Carl Perkins Vocational Education Act, is focused on assisting States in increasing access for special populations to quality vocational programs and assisting the States in improving, expanding and initiating vocational programs.

While the Federal share is only $1 of every $10 funding vocational education, this minor share is important in providing incentives and leverage for States to address national priorities.

We in vocational education are concerned about the Federal share of vocational education funds—concerned because the need for vocational education continues to increase, and concerned because this administration proposed to reduce the Federal share while we continue to face rising program costs.

Since 1980, vocational funding on the Federal level has been reduced by 28 percent in real dollar terms.

Even with the much-needed supplemental appropriations passed by Congress in 1986, we still have a great many unmet needs.

The vocational community is recommending that vocational funding in fiscal 1987 be maintained at current service levels to allow our programs to keep up with current costs of providing training and education.

Fiscal year 1986 appropriation: $849,648,000.

Fiscal year 1986 current service levels: $874,923,000.

Vocational education addresses a number of critical national issues.

My testimony, which I am submitting for the record, will give you a brief overview of vocational education today, showing how vocational education:

Strengthens national defense;

Combats the dropout rate from our secondary schools;

Strengthens basic academic skills;

Trains and retrains adults displaced from their work; and

Promotes economic development in communities.

These are all issues that we feel are important in 1986.

The AVA, on behalf of the vocational educational enterprise, is asking Congress to fund vocational education at a current service level for fiscal 1987.

Without such Federal funding, States would be forced to cut back or eliminate many of their exemplary programs and program improvement initiatives, as well as reduce services and programs to those at-risk groups most in need of training and jobs.

Mr. Chairman, AVA remains mindful of the fiscal restraints Congress is facing, but we feel that funding vocational education remains a core function of the Federal Government. We have spent our money wisely in the past and have made significant contributions to the well-being of the nation.

The members and leaders of AVA appreciate the support you have given vocational education, and we are ready to work with you to fund vocational education in fiscal year 1987.

Thank you.

[The statement of Ms. Kolde follows:]

STATEMENT
OF
ROSEMARY KOLDE
PRESIDENT
OF THE
AMERICAN VOCATIONAL ASSOCIATION

BEFORE THE
HOUSE APPROPRIATIONS
SUBCOMMITTEE
ON
LABOR, HHS, EDUCATION

THE HONORABLE WILLIAM NATCHER
CHAIRMAN

APRIL 29, 1986

Good morning, Mr. Chairman, I am Rosemary Kolde, Associate Superintendent of the Great Oaks Joint Vocational School District in Cincinnati, Ohio, and President of the American Vocational Association (AVA). AVA is the primary professional association for 50,000 vocational educators who provide job training in every community in the nation.

I am pleased to have the opportunity today to appear before your subcommittee and make recommendations for fiscal 1987 appropriations for vocational education.

Vocational education, as a part of our public, tax-supported educational system, affects the livelihood of 19.5 million vocational students. There are 375,000 vocational teachers in 28,000 institutions located in every community in every state.

Vocational education, by its nature and the expectations placed upon it, is a complex enterprise. It is the primary system that provides the necessary bridge between school and the workplace. Specific technical preparation, basic academic skills as they relate to employment, and general employability skills are imparted to the vocational student whether he or she is taking a home economics course in Bowling Green, Kentucky, a quick-start adult training/retraining course in Pittsfield, Massachusetts, or a computer-aided drafting course in Wausau, Wisconsin. Vocational education is community-based and relevant to people's needs. Vocational education is a national resource.

Vocational education has historically been funded by a strong federal, state, and local partnership. The federal dollar, driven by the Carl Perkins

Vocational Education Act, is focused on assisting states in increasing access for special populations to quality vocational programs and assisting states in improving, expanding, and initiating vocational programs. In addition to these basic programs, the Perkins Act provides support for consumer and homemaking education, cooperative programs with community-based organizations, bilingual vocational training programs, and national programs of research and assessment. While the federal share is only $1 of every $10 funding vocational education, this modest, marginal investment has been extremely successful in providing incentives and leverage for states to address national priorities in education and training.

We in vocational education are concerned about the federal share of vocational education funds. We are concerned because the need for vocational education continues to increase. We are concerned because this administration proposed to reduce the federal share and we are concerned because we continue to face rising program costs. Since fiscal year 1980, vocational funding on the federal level has been reduced by 28 percent in real dollar terms. Even given the much needed supplemental appropriations passed by Congress in fiscal 1985 and annualized in fiscal 1986, we still have unmet needs.

The vocational education community is recommending that vocational funding in fiscal 1987 be maintained at current services levels to allow vocational programs to keep up with the current costs of providing training and education.

THE RECOMMENDATION OF THE AMERICAN VOCATIONAL ASSOCIATION

Program	FY86 Appropriations	FY87 Current Services Level
Basic State Grants (Title II)	$782,381,000	$826,976,717
Community Based Organizations (Title III-A)	$7,500,000	$7,927,500
Consumer and Homemaking Education (Title III-B)	$31,633,000	$33,436,081
State Councils	$7,300,000	$7,716,100
Smith-Hughes Permanent Appropriations	$7,148,000	$7,148,000
National Programs	$10,000,000	$10,570,000
Bilingual Vocational Programs	$3,686,000	$3,896,102
TOTAL	$849,648,000	$897,670,500

NATIONAL PRIORITIES

How does vocational education contribute to the national well-being? How can we justify funding this program? Vocational education directly addresses a number of critical national concerns. Mr. Chairman, my statement will give you brief snapshots of the vocational enterprise in our country today — snapshots that, taken together, give a clear picture of how vocational education contributes to deficit reduction, strengthens national defense, combats the dropout rate from our secondary schools, strengthens basic academic skills as part of a job training program, trains and retrains adults displaced from their work, and promotes economic development in communities. These are the issues we in the vocational community feel are important in 1986.

DEFICIT REDUCTION

Vocational education reduces the federal deficit by increasing federal revenue and decreasing federal expenditures.

Vocational graduates earn more than non-vocational graduates (Suk Kang, 1985), are more likely to be employed (NAB/NCRVE, 1984), and thus, contribute more in taxes. In addition, quality vocational education programs can play a significant role in preventing dropouts from leaving school and adding to the government's unemployment and welfare payments. Hess and Lauber (1985) estimate that, in Chicago, for every $1 invested to combat the dropout problem, city taxpayers save $12.49. Part of that $1 investment supports services provided in vocational institutions.

Over the last six years, federal funding for vocational education has decreased by 28 percent in real dollar terms and vocational education's share of the federal budget has decreased 67 percent. The numbers tell a clear story. Vocational education is a cost effective program which has and will continue to contribute to deficit reduction.

NATIONAL DEFENSE

Approximately 750,000 vocational graduates each year choose to enter the military. The vocational programs they have taken provide them with technical knowledge, basic occupational skills, and leadership training -- traits and employability characteristics that both employers and the military value. For instance, a recent study (Nunez and Russell, 1982) indicated that 85 percent of the employers surveyed preferred hiring vocational graduates rather than non-vocational graduates for jobs requiring less than a four-year degree. Those graduates are just as attractive to the military as they are to the private sector.

Vocational institutions also provide training to active and reserve military personnel along with National Guardsmen. The training they receive in vocational institutions enables them to operate and maintain the complex weapons they encounter in the military. Program improvement funds under the Perkins Act can support these activities.

For example, Clover Park Vocational-Technical Institute in Tacoma, Washington has, for the past 25 years, provided training to Army and Air Force personnel from nearby Fort Lewis and McChord Air Force Base. The training has covered such areas as supervisory management, airframe and powerplant maintenance, telephone installation and maintenance, automotive mechanics, and others. These programs have a dual purpose -- to increase the technical proficiency of active military personnel and to prepare those individuals for further employment upon separation from military service. Thousands of military personnel, both Army and Air Force, have benefited from Clover Park's training programs.

DROPOUT PREVENTION

Our quality vocational programs and schools are central partners in an ongoing effort to combat dropouts. Secondary students drop out of school for a number of complicated, interrelated reasons -- including pregnancy, marriage, employment outside of school, or disenchantment with school.

For whatever reason students drop out, the problem is urgent and growing. Thirty percent of the students entering high school do not graduate; in some urban areas, the figure is 40 or 50 percent. The costs to this country are staggering. Catterall (1985) estimates that at least $20 billion per year is lost because of the dropout problem through taxes, welfare, unemployment, and crime.

Just as clear is that vocational education and work experience, when utilized early enough and well enough, are, according to Lotto (1982), "powerful components" in the fight to prevent dropouts.

For instance, the GRADS program, a home economics program in Ohio, works with teenage parents to encourage them to complete their education. Resources are used to provide child care, child development and parenting information, and job counseling. Nationwide, the dropout rate for teenage parents, according to the National Center for Education Statistics, is 80 percent. Over 88 percent of the participants in the GRADS program graduate from high school.

What works best with dropouts, according to Weber (1986), is a combination of vocational instruction, work experience/job placement, job counseling, support services, basic skills instruction, and parental involvement. These are components of quality vocational education programs.

It makes sense to fund the Carl Perkins Vocational Education Act to help states address the dropout program through their vocational education programs.

BASIC SKILLS

Quality vocational education, whether it is targeted to dropouts or other secondary students, provides a meaningful setting for strengthening critical basic academic skills. This instruction is directly related to the occupational training and employment preparation received by the vocational student. Results from a recent study (Weber, 1986) demonstrate that vocational students' rate of achievement equals or surpasses the rate of achievement for students in the general education track in five of seven basic areas of academic skills. This is most impressive because it clearly indicates that a host of related subject areas, including basic remedial education, are integral to the vocational curriculum.

ADULT TRAINING & RETRAINING

Vocational education programs in many states are being called upon to meet the training and retraining needs of adults. Today's workplace is rapidly changing. An 18-year-old can expect to hold a minimum of 10 jobs and switch careers four or five times before retirement. At the same time, the Baby Boom generation, the 70 million people born between 1945 and 1960, is in the midst of its prime earning and learning years. They too are switching jobs and careers and need job training. People who have traditionally not been in the American workforce are entering the job market at an increasing rate. By the year 2000, women will constitute over half the nation's blue-collar workforce, and 60 percent of all adult women will be in the job market.

The very nature of the jobs people hold is quickly being transformed by the introduction of advanced technologies and the rising dominance of the service sector in the American economy. This economic transformation will result in dramatic growth in jobs requiring relatively low skills along with a corresponding growth in jobs requiring complex, highly developed skills. The semi-skilled jobs that have traditionally been the backbone of the service industry will be drastically reduced.

Two million workers are now the obsolete remnants of our once prosperous manufacturing industries. The National Commission on Industrial Innovation estimates that, without the necessary training, another two to three million workers will be dislocated before the end of the decade. There is a clear responsibility to provide those workers with the training and education they will need to remain gainfully employed — precisely the type of training that can be successfully offered by this nation's vocational institutions.

It makes sense to fund the Carl Perkins Act to ensure that our primary job training delivery system stays strong and that the signal is not sent to the states that the federal government is unwilling to meet the training needs of youth and adults.

SUMMARY

When we talk about vocational education's ability to reduce the budget deficit, train and retrain adults, strengthen basic skills, reduce the dropout rate, and contribute to our national defense, we are really focusing on vocational education's ability to stimulate economic growth and development through its successful development of employability skills.

New research has shown that vocational education leads to long-term positive benefits in terms of graduates' earnings and productivity. A joint study by the National Alliance of Business and the Ohio State University found that new employees with relevant vocational education

- ° were 6.5 percent more productive compared to non-vocational graduates 36 months after being hired,
- ° required 20 percent less formal on-the-job training,
- ° had higher wage rates, and
- ° increased the firm's output and reduced training costs by considerably more than additional wages paid.

According to a 1985 study (Campbell and Basinger), vocational graduates continue to enjoy significant advantages in hourly and monthly earnings up to seven years after high school graduation, compared to students in general education.

Mr. Chairman, employers recognize the contribution vocational graduates can bring to their companies. For example, more than 800,000 individuals employed by private sector corporations volunteer to advise vocational programs.

Mr. Chairman, it is of primary importance to maintain the federal partnership in vocational education. These programs contribute to a strong national defense. They make a significant contribution towards helping prevent dropouts and serve teenage parents. Initiatives at the state and local level to train and retrain adults and increase the economic development of this country are dependent on vocational education. They must be continued.

The American Vocational Association, on behalf of the vocational education enterprise, is asking Congress to fund vocational education at a current services level for fiscal 1987. The federal, state, and local partnership that has supported vocational education since 1917 is, Mr. Chairman, often likened to a three-legged table. If one of the legs is shortened, or removed, then the whole table might topple. The argument put forth that the federal role is insignificant is unconvincing. We know that states will be hard pressed to continue vocational services in the absence of federal support.

The American Vocational Association has found in a recent survey that without federal funding, states would be forced to cut back or eliminate career guidance and counseling, wipe out many exemplary programs like the GRADS program in Ohio, halt or curtail critical program improvement initiatives, eliminate many consumer and homemaking education programs, and reduce services and programs for those at-risk groups most in need of training and jobs.

Mr. Chairman, while AVA remains mindful of the fiscal restraints Congress is facing, we feel that funding vocational education remains a core function of the federal government. Our members have been faithful stewards of these funds and with them have made significant contributions to the well-being of our nation.

The members and leaders of AVA appreciate the support you have given vocational education and we stand ready to work with you to fund vocational education in fiscal 1987.

REFERENCES

Campbell, P., and Basinger, K. *Economic and Non-economic Effects of Vocational Education*. Columbus: The National Center for Research in Vocational Education, The Ohio State University, 1985.

Catterall, J. "On the Social Costs of Dropping Out of School." Los Angeles: University of California — Los Angeles, December 1985.

Hess, G. A., and Lauber, D. *Dropouts from the Chicago Public Schools*. Chicago: Chicago Panel on Public School Finances, 1985.

Kang, S., and Bishop, J. *The Effects of Curriculum on Labor Market Success Immediately after High School*. Columbus: The National Center for Research in Vocational Education, The Ohio State University, 1985.

Lotto, L. "The Holding Power of Vocational Curricula: Characteristics of Effective Dropout Prevention Programs." *Journal of Vocational Education Research* 7, No. 4 (1982): pp. 39-49.

National Alliance of Business and The National Center for Research in Vocational Education. "Research You Can Use." 8-84: No. 4 (1984).

National Commission on Industrial Innovation. *Potential Worker Dislocation Impacts of New Technology in the U.S. Economy over the Next Decade*. 1984.

Nunez, A., and Russell, J. *As Others See Vocational Education. Book 1: A Survey of the National Association of Manufacturers*. Columbus: The National Center for Research in Vocational Education, The Ohio State University, 1982.

Weber, J. M. *The Role of Vocational Education in Decreasing the Dropout Rate.* Columbus: The National Center for Research in Vocational Education, The Ohio State University, 1986.

Mr. NATCHER. Thank you very much, Ms. Kolde. You made an excellent statement and we appreciate your appearance before our committee.

TUESDAY, APRIL 29, 1986.

HEALTH RESEARCH, HEALTH MANPOWER

WITNESS

DR. LOUIS W. SULLIVAN, PRESIDENT AND DEAN, MOREHOUSE SCHOOL OF MEDICINE

Mr. NATCHER. Our next witness is Dr. Sullivan. Doctor, you take the same chair you did this morning. We will be glad to hear from you.

Dr. SULLIVAN. Thank you very much. This afternoon I am here on behalf of the Morehouse School of Medicine and I appreciate very much this opportunity of appearing before you.

I wish to give you a progress report on our institution, which has been so generously funded by this committee and the actions of its Members, and relate some of our plans for the future.

As you know from my previous appearance before this committee, the Morehouse School of Medicine came into being to address the national need for black physicians and physicians from other minority groups as well as to train more physicians in family medicine and other primary care specialties to work in medically underserved rural areas and inner cities.

The Morehouse School of Medicine, after five years of planning, opened in 1978, as a two-year medical school in the basic medical sciences, with our first three classes, transferring to other four-year medical schools for the completion of their M.D. training. These other schools included Emory Medical College of Georgia, University of Alabama in Birmingham, Howard University, Brown University and Rush Medical School, and the University of North Carolina in Chapel Hill and Louisiana State University.

At all of those institutions where students transferred, they performed quite well.

In 1981, the Morehouse School of Medicine received a charter from the State of Georgia to award the M.D. degree. The first class to stay with us for our entire four years graduated one year ago in May of 1985. There were 20 new physicians in our charter M.D. graduating class who are now in residency training physicians in Georgia and around the country.

We were also pleased toward our first honorary degree on May 17, 1985, to Congressman Louis Stokes for his leadership, guidance, and assistance in the development of our institution. We also were honored to have Congressman Silvio Conte at our first commencement weekend to receive the Morehouse School of Medicine Institutional Leadership Award for his great assistance over the years in the development of our institution. We are grateful to both of these gentlemen and to the other Members of the committee for your support.

The Morehouse School of Medicine has come into being to address the national need as briefly noted. That need includes addressing the disparity and health status of blacks and other minorities in our society. This disparity is reflected in an infant mortality rate among blacks that is twice as high among whites; the life expectancy is five to six years less for blacks than whites, and a high incidence of heart disease, cancer, diabetes, and other disorders. This disparity results in 60,000 excess deaths annually in the black population, as estimated by the Task Force of the Secretary of the Department of Health and Human Services in their report to the Secretary in August of 1985.

Our students at the Morehouse School of Medicine come from all over the country; and from Morehouse they are going all over the country for postgraduate training and for practice including such cities as Boston, Cleveland, Chicago, San Diego, New York, Washington, and other cities.

From the beginning, we have been generously supported by the Congress and for this we are very grateful. We have received grants for curriculum development, facilities, equipment, faculty development and soon financial aid.

I am pleased to report to you that as a result of your support, the Morehouse School of Medicine completed its first decade on June 30, 1985, with the following achievements:

A. Our students have a 95 percent passing rate on Part I of the National Board Examination, a nationally administered examination, comparing favorably with students from all other medical schools in the United States.

B. Our faculty has been successful in competing for research grants from the National Institutes of Health, the National Science Foundation and other sources.

C. Our administrative staff has carefully utilized our fiscal resources so that the medical school has always operated fiscally in the black. We have never had an operating deficit.

Thus, we can report to you that you have invested our Nation's resources on behalf of the American people in the development of a quality institution that is providing leadership in the nation and addressing critical medical education and health care needs.

We at Morehouse have been fortunate to receive, with the assistance of this committee, a grant from the U.S. Department of Education through its Title III program of $3,000,000 annually to assist in our development from a two-year to a four-year school. This grant has enabled us to develop an effective Federal-State-private partnership for the medical school. As a result of the grant from the Department of Education, we have been able to obtain a similar grant from the State of Georgia $3,000,000 annually for the medical school, in addition to which we received capitation funds from the States of Georgia, New York and Alabama based upon the number of students from these respective States enrolled in our medical school. We have been fortunate in developing these relationships because of the recognition of these three States of the great need for an institution such as ours to train more black and other minority physicians.

We have just successfully concluded this past January 30th our first national campaign for private sector support. In this campaign we received $15,000,000, $10,000,000 of which was from private sources, to assist in the development of the medical school. The other $5,000,000 was appropriated by this committee to assist us in the construction of our second medical education building. This has been possible because of the Challenge Grant received from the Department of Education, with the help of the Members of this committee and our other friends in the Congress.

At this time in the history of our institution, we are very proud of our development, but also aware of our present need for continued development of the Morehouse School of Medicine into an outstanding institution for the education of more minority physicians and for the development of a program of excellence in biomedical research.

Therefore, we earnestly request the support of this committee for funding of the Department of Education's Title III program sufficient to allow for a grant of $5,000,000 to the Morehouse School of Medicine annually beginning in fiscal year 1987 to continue our development of a quality institution. In our discussions with State officials, we have been very encouraged by their interest in our institution and their desire to continue matching the Federal support that we are receiving.

We also urge that you provide full funding for the research centers at minority institution programs of the National Institutes of Health, a program which was instituted due to your leadership, Mr. Chairman, and the leadership of Mr. Stokes and Mr. Conte. A number of minority institutions have received awards under this program, and Morehouse is presently anticipating the receipt of an award within a short period due to the work of this committee. Such an award will strengthen our institution as well as provide for a stronger research capability now and in the future at our institution.

We are very much concerned about the increasing debt burden of our graduating students from the Morehouse School of Medicine, a reflection of a nationwide trend due to a continued reduction in funds available for student scholarships and a reduction in low interest loans. We respectfully request that this committee again provide full funding for the various student scholarship programs such as the health professions Student loan programs, the guaranteed student loan program, and others, to assure that young people with talent are not deterred from pursuing a medical education because of lack of funds.

In this regard, I hasten to report to you that preliminary evidence now being reported from the Association of Minority Health Professions Schools, based on a survey of data from the Association of American Medical Colleges, indicates that there is underway a dramatic change in the socio-economic profile of entering medical students at schools not only at Morehouse but at all medical schools around the country. That change reflects a significant drop in students entering medical schools who come from families earning less than $20,000 a year and a significant increase in the percentage of students coming from families earning $60,000 a year or more.

Thus, we are greatly concerned that students who are talented and who despite medical education are not able to pursue this because of lack of available student scholarship and loan monies to support their medical education. We need to have these people from a variety of socio-economic backgrounds to address the health care needs of our entire population and not simply those individuals who live in affluent suburban communities.

Again, it is a pleasure to have this opportunity to appear before you to give you this progress report on the Morehouse School of Medicine. Thank you for your past support. Schools like Morehouse need your continued support as we work to address one of our Nation's most pressing needs: improving health services for our minority and low income people and citizens who reside in medically underserved rural and inner city areas; and increasing the number of physicians who come from poor and minority backgrounds to address the health care needs for our fellow citizens. Thank you again for this opportunity to share with you our views.

Mr. NATCHER. Thank you very much, Dr. Sullivan. You have made an excellent statement and we appreciate your appearance.

TUESDAY, APRIL 29, 1986.

VOCATIONAL EDUCATION

WITNESSES

NELLIE C. WEIL, PRESIDENT, NATIONAL SCHOOL BOARDS ASSOCIATION
THOMAS A. SHANNON, EXECUTIVE DIRECTOR
MICHAEL A. RESNICK, ASSOCIATE EXECUTIVE DIRECTOR
EDWARD R. KEALY, DIRECTOR, FEDERAL PROGRAMS

Mr. NATCHER. Our next witness is Ms. Weil. Come around, Ms. Weil. We are delighted to have you before the committee.

Ms. WEIL. Thank you, Mr. Chairman. It is my pleasure to be here this afternoon. I am Nellie Weil, President of the National School Boards Association, representing the 95,000 school board members in this nation. Since 1980, Federal eduction programs have been reduced through cuts, freezes and inflation. NSBA believes that fiscal year 1987 is the year that this disheartening pattern should stop. The Andrews-Hollings amendment adopted by the Senate opened an opportunity for that body to fund education programs at pre-Gramm-Rudman levels, plus inflation. Members of the House Budget Committee are also prepared to seek increases beyond the original 1986 level.

We urge this subcommittee to adopt funding which is at least at the pre-Gramm-Rudman current service level for fiscal year 1987.

The long-term decline in Federal funding will make it almost impossible for local school districts to maintain quality education programs and equity.

We very much appreciate your past efforts to maintain education funding levels despite deficit reduction pressures. Viewed over six years, we believe that education has now contributed to deficit reduction. The budget for elementary-secondary education was $7,042,000,000 in fiscal year 1980, slightly more than last year's postsequestration level of $7,300,000,000.

With inflation rates averaging 5.9 percent since 1980, a freeze this year actually represents a 35 percent cut in Federal education funding. The Federal contribution to elementary and secondary education programs has dwindled from 1.1 percent to less than .7

of 1 percent since 1980, a decline of 40 percent. This clearly shows education's decline as a priority in the Nation's budget.

The House and Senate wisely rejected the administration's budget request and the argument that State and local government can absorb reductions in Federal education expenditures. State and local communities, affected by the dramatic drop in oil prices, the escalating foreign prices and losses in manufacturing, find it difficult to maintain their current commitments to education, much less make up for the reductions. Many States are cutting their budgets for next year, and Alabama is one of them. Let me highlight several of our funding recommendations.

Chapter 1, an effective program as you have already been told, serves 4,800,000 disadvantaged students. The number of poor children is increasing dramatically, and Chapter 1 has been subject to a freeze, and then a Gramm-Rudman sequestration of $159,000,000. Chapter 1 simply cannot afford this. We urge you to appropriate at least an additional $378,000,000 to return Chapter 1 to the original fiscal year 1986 service levels.

Public Law 94-143 authorizes the Federal Government to cover 40 percent of the excess cost to educate the handicapped. It's share never rose above 12 percent and now hovers about 9 percent. This trend to abandon the Federal obligation must end. We urge the committee to appropriate at least an additional $142 million to maintain the Federal commitment to this very worthwhile program.

Chapter 2 has succeeded in helping local school districts provide a variety of school improvement activities, a bill recently introduced by Representatives Hawkins and Goodling would further increase the efficacy of the Chapter 2 program by earmarking 50 percent of the set-aside for effective school research.

NSBA recommends an additional $3,000,000 to allow local school districts to maintain local school improvement programs.

The proposal to cut funding for the Perkins Vocational Education Act in half is based on the rationale that vocational education is not effective, and detraction from academic preparation. NSBA strongly disagrees with this attitude. These funds for program improvements and innovations are vitally necessary to retool and upgrade programs to meet future job market needs in local communities. NSBA recommends an additional $95,000,000 to maintain vocational and adult education at a pre-Gramm-Rudman service level.

We have not asked the committee to make dramatic increases in education funding. We do not believe that education has contributed to the deficit. It is a sound investment. We have asked that you take the first step to reverse a destructive trend in the cuts and the freezes. As locally elected and appointed officials, we believe the Nation truly supports a very high priority for public education in the Federal budget.

Thank you very much, Mr. Chairman.

Mr. NATCHER. Thank you very much, Ms. Weil. You made an excellent statement and we appreciate your appearance.

TUESDAY, APRIL 29, 1986.

EDUCATION FOR THE HANDICAPPED, REHABILITATION SERVICES

WITNESS

ROBERT DAVILA, PRESIDENT-ELECT, CONFERENCE OF EDUCATIONAL ADMINISTRATORS SERVING THE DEAF

Mr. NATCHER. Our next witness is Mr. Robert Davila. We are glad to have you back before the committee. You have appeared before our committee on several occasions. It is always a pleasure to have you. We will be glad to hear from you.

Mr. DAVILA. Thank you very much.

Mr. Chairman, Members of the subcommittee, the Conference of Educational Administrators Serving the Deaf (CEASD) was founded in 1869 and is an organization of schools and programs which provide educational services to deaf persons. Among its member organizations are a number of State-operated programs that are recipients of Chapter I, ECIA funds.

The conference is active in developing and administering standards for services related to education of the deaf. We appreciate this opportunity to discuss our concerns regarding appropriations for programs authorized under Chapter I, ECIA. Our statement is restricted to the program as it relates to services for deaf students.

Mr. Chairman, we urge you and your committee to support nothing less than a 5 percent increase funding level of at least $167,000,000. We urge that the goal should be appropriate support for both Public Law 94-142 and Chapter I, ECIA.

The administration has used, in part, an equity argument for reducing funds to the Chapter I program; an argument that funding should be more like the level of funding under Public Law 94-142. It would appear that Congress did not conceive of the program in relation to Public Law 94-142, and that it would to be appropriate to do so now. The equity argument does not appropriately take into account what may be systematic differences in populations served.

If programs for the deaf are considered, there are a variety of population differences which may warrant increased allocation of resources to State-operated programs. The student population in center or residential schools is older, more severely handicapped and less successful in finding appropriate post-school placements.

Our organization is strongly supportive of the goals of Public Law 94-142 which include the promotion of a full range of educational service delivery options within which the State-operated programs, including center and/or residential schools, play an important role. The programs tend to represent appropriate placement options for a substantial proportion of deaf students who cannot be served adequately by local programs. Continuity of Chapter I support can assist these schools to better serve these students.

Mr. Chairman, we would like to have the committee aware of the following:

1. Important services are delivered to deaf students and their parents through the Chapter I program.

2. In education of the deaf, Chapter I (89-313) funding has been an important source of change and improvement.

3. If appropriations levels are affected by the Balanced Budget Act of 1985, it will have significant negative impact on the lives of numerous deaf children and their parents.

Mr. Chairman, it is important to note that the Public Law 89-313 program has been responsible for significant innovation in programs for the deaf.

We would also like to express our support for the recommendations of the National Rehabilitation Coalition, of which we are a member. The programs included under the Rehabilitation Act of 1973, which includes needed services for the hearing impaired, provide disabled citizens with the opportunity to be a part of the mainstream of life as full participants.

Thank you very much.

[The statement of Mr. Davila follows:]

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Testimony

before the

House Appropriations Subcommittee
on Labor-Health and Human Services-Education

regarding

FY 87 Appropriations for Programs Authorized Under
Chapter I ECIA. 1981

Honorable William H. Natcher, Chairman

April 29, 1986

presented by

Dr. Robert Davila, President-Elect
Conference of Educational Administrators
Serving the Deaf, Inc.
Silver Spring, Maryland

On behalf of

The Conference of Educational Administrators
Serving the Deaf (CEASD)

and supported by

The Convention of American Instructors of the Deaf (CAID)
and
The Registry of Interpreters of the Deaf (RID)

TESTIMONY BEFORE THE HOUSE APPROPRIATIONS SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES REGARDING FY 87 APPROPRIATIONS AND PROGRAMS AUTHORIZED UNDER CHAPTER I ECIA, 1981

The Conference of Educational Administrators Serving the Deaf (CEASD) was founded in 1869 and is an organization of schools and programs which provide educational services to deaf persons. Among its member organizations are a number of state operated schools/programs that are recipients of Chapter I (Education Consolidation and Improvement Act, 1981) funds. The Conference is active in developing and administering standards for services related to education of the deaf. We appreciate this opportunity to discuss our concerns regarding appropriations for programs authorized under Chapter I, ECIA. Our statement is restricted to the program as it relates to services which benefit deaf students.

Mr. Chairman, we urge you and your committee to support nothing less than a 5% increased funding level of at least $167.0 million. We urge that the goal should be appropriate support for both P.L. 94-142 and Chapter I, ECIA.

The Administration has used, in part, an equity argument for reducing funds to the Chapter I program; an argument that funding should be more like the level of funding under P.L. 94-142. It would appear that Congress did not conceive of the program in relation to P.L. 94-142, and that it would not be appropriate to do so now. The equity argument does not appropriately take into account what may be systematic differences in populations served. If programs for the deaf are considered, there are a variety of population differences which may warrant a disproportionate allocation of resources to state operated programs. The student population in center or residential schools is older, more severely handicapped and less successful in finding appropriate post-school placements.

Our organization is strongly supportive of the goals of P.L. 94-142 which include the promotion of a full range of educational service delivery options within which the state operated programs, including center and/or residential schools, play an important role. The programs tend to represent appropriate placement options for a substantial proportion of deaf students who cannot be served adequately by local programs. Continuity of Chapter I support can assist these schools to better serve these students.

Mr. Chairman, we would like to have the committee aware of the following:

1) Important services are delivered to deaf students and their parents through the Chapter I program.
2) In education of the deaf, Chapter I (89-313) funding has been an important source of change and improvement.
3) If appropriations levels are affected by the Balanced Budget & Emergency Deficit Control Act of 1985, it will have significant negative impact on the lives of numerous deaf children and their parents.

Mr. Chairman, it is important to note that the P.L. 89-313 program has been responsible for significant innovation in programs (for the deaf). Included among the many programs initiated by P.L. 89-313 funding are:

1) in service training;
2) parent education;
3) services for the multihandicapped;
4) computer assisted instruction;
5) orientation and mobility training;
6) psychological services;
7) perceptual motor diagnostic; and
8) residence hall teacher program

Mr. chairman, we again urge your support of at least $167.0 million as an appropriate and needed appropriations level for the Chapter I program for the handicapped.

We would also like to express our support of the recommendations of the National Rehabilitation Coalition, of which we are a member. The programs included under the Rehabilitation Act of 1973, which includes needed services for the hearing impaired, provide disabled citizens with the opportunity to be a part of the mainstream of life as full participants.

Thank you very much.

REHABILITATION ACT OF 1973, AS AMENDED
($ in millions)

Program	FY86 Appropriation	FY86 Post Sequestration	FY87 Authorization	Administration FY87 Budget	Coalition's Recommendation
Basic State Grant	$1,190.0	$1,145.0*	Pending	$1,100.0	$1,379.4
Evaluation (Sec. 14)	2.0	1.914	Pending	.6	2.0
Training	27.0	25.839	Pending	15.0	32.0
National Institute of Handicapped Research	44.0	42.108	Pending	39.0	49.0
Innovation & Expansion	9.0	8.613	Pending	9.0	9.0
Independent Living					
Comprehensive State Services, Part A	11.0	10.527	Pending	---	30.0
Centers for Indepen. Living, Part B	23.0	22.011	Pending	22.0	26.0
Services to Older Blind Individuals, Part C	5.0	4.785	Pending	---	5.5
Service Projects:					
Client Assistance	6.7	6.4119	Pending	6.3	7.5
Special Demonstration Projects	20.2	19.33	Pending	14.6	30.6
Projects with Industry	15.2	14.5464	Pending	13.0	18.0
Special Recreation Programs	2.2	2.1054	Pending	---	4.5
Helen Keller National Center	4.3	4.1151	Pending	4.2	5.5
Archit. and Trans. Barriers Compliance Board	1.97	1.89	Pending	1.97	2.5

*This represents the cost of living reduction for section 110.

Mr. NATCHER. We want to thank you for your appearance before our committee. You made an excellent statement. You have appeared before our committee on a number of occasions down through the years, and we appreciate your attendance. This is one of the most important programs that we have in this bill. We want to thank you again. Thank you very much.

TUESDAY, APRIL 29, 1986.

MEDICARE, NHSC, AIDS, PROPAC

WITNESS

JACK OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. NATCHER. Our next witness is Mr. Owen. Come around, Mr. Owen. We will be pleased to hear from you, Mr. Owen.

Mr. OWEN. Thank you, Mr. Chairman.

My name is Jack Owen, Executive Vice President of the American Hospital Association and Director of the Washington office. You have my statement, so I would like to make a few points.

We understand very clearly the problem that you and other Members of Congress have with the problem of a budget deficit, and we can understand the difficulty that you have to face in appropriating money for many of these programs. However, we feel that the health care field, the hospital field has done what everyone in Congress expected them to do under the new prospective pricing system. We have made it work. The hospital trust fund, which was supposed to be bankrupt in 1987, has now been, it has now been indicated by OMB and CBO that it is good through the 1990s, but we cannot continue to provide the kind of care that we have for the elderly without trained staff.

We are finding that we have more and more, that patients are spending less time in hospitals, and that there is more need of home health care, transitional care, skilled nursing care. You heard about letting patients go "quicker and sicker," as Senator Heinz has said. We don't think they are sicker but we do need trained people to take care of them.

Where nurses are going to come from concerns us and some of the other health professionals. As we take care of the elderly patients in our hospitals, get them out much faster to skilled nursing facilities, home health care programs, we find that we have got some very severe sick people in the hospitals, and we need highly trained people to take care of these people. The severity increases and the length of stay decreases. We would hope that this committee would maintain the $148,000,000 level approved by Congress for the educational programs.

I would like to comment on four other programs. The National Health Service Corps, there is a lot of talk about there is a surplus of physicians, we don't need to train physicians anymore. There are lots of places in this country where it is still very difficult to get a physician, some more rural parts of the States, the inner cities, underserved areas of our country, and we need to continue the National Health Service Corps.

Another program which is rather new as far as the budget needs are concerned is the AIDS program. We had about $244,000,000 appropriated in 1986 to handle the AIDS problem, and it is being reduced to $203,000,000 and yet we know the number of patients with AIDS is increasing drastically. The cost of caring for the first 10,000 patients with AIDS is estimated at $1,400,000,000, by the CDC. We think money should be appropriated to see if there can't be ways to stem the rise of this disease.

The other area is the money that goes to Medicare contractors.

Our hospitals continue to take care of the elderly and expect to be paid, hopefully, on time. The extension of payment to hospitals is being stretched out longer and longer and running now close to 45 days. And without enough money to see that the hospitals are paid quickly, we have a number of institutions that are going to be in a very serious cash flow problem.

Finally, we support the $3,400,000 for the prospective payment assessment Commission, ProPAC, one of the few physicians looking at the home care program, and it is needed to keep a review of the system as an outside agency.

Thank you, Mr. Chairman.

Mr. NATCHER. Mr. Owens, thank you. You made an excellent statement. We appreciate your appearance.

[Mr. Owens statement follows:]

American Hospital Association

AHA

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATON
OF THE
HOUSE APPROPRIATIONS COMMITTEE

April 29, 1986

The American Hospital Association, which represents 5,600 institutions and 40,000 personal members, is pleased to have this opportunity to present its view on the Administration's Fiscal Year 1987 appropriations request for the Department of Health and Human Services. There are several areas of the Adminstration's request that are of particular interest to hospitals: health professions education; the National Health Service Corps; Acquired Immune Deficiency Syndrome (AIDS) research and education; Medicare contractors; and the Prospective Payment Assessment Commission.

I am Jack W. Owen, Executive Vice President of the American Hospital Association. On behalf of the 5,600 institutional and 40,000 personal members of the Association, I am pleased to present our views on the Administration's Fiscal Year 1987 appropriations request.

The AHA represents over 200 hospital schools of nursing as well as more than 2,500 personal members in the AHA-affiliated American Organization of Nurse Executives. Nurses are key figures in any hospital, and they are assuming more responsibility in today's hospitals. Shortages of nurses still persist in certain geographic areas.

As employers and educators of health care personnel, hospitals are deeply concerned about adequate federal funding of health professionals education programs. To fulfill their commitment to deliver high-quality care, hospitals need an adequate supply of qualified professionals and competent technical personnel. Moreover, hospitals are involved directly in all levels of health personnel training: they operate hospital-based schools of nursing and offer clinical experience to undergraduate and advanced students in collegiate programs.

The Administration's budget for FY 1987 would eliminate all federal funding for nursing education and research programs, including funds for the newly created National Center for Nursing Research at the National Institutes of Health, saving $63.9 million, the amount provided for nursing programs in FY 1986. Programs subject to the total cut include those for advanced nurse training, nurse practitioners, professional traineeships, nurse anesthetists, research grants, demonstration projects, and other special projects. AHA is opposed to these cuts. These programs provide education and training opportunities for nursing students, educators, executives, and clinical specialists in areas such as home health care, geriatric and long-term care, maternal and child health care, and rural health care. Research programs and grants focus on the cost-effective delivery of health care services, particularly for high-risk populations including the elderly, premature newborns, the chronically ill, and the disabled and dying.

The ever-increasing demands for skilled personnel make continued funding of health professions education programs more necessary than ever. Technological advances are creating new occupations each year. At a time when federal payment and utilization control policies are encouraging shorter lengths of stay and greater use of outpatient services, hospitals are being called on to provide more intensive services to a greater proportion of seriously ill patients. The prospective pricing system undoubtedly will place additional demands on hospital personnel as incentives for cost-effective management are reconciled with the continuing responsibility to deliver high-quality care.

The President's 1987 budget requests no funds for health professions education programs. AHA believes that the federal government should maintain its commitment to health professions education and supports a funding level of $148 million for FY 1987, consistent with the level approved by Congress in the Health Professions Educational Assistance Amendment of 1985 (P.L. 99-129).

The National Health Service Corps is a primary force in meeting the needs of medically underserved areas, and AHA strongly supports its work. Although the increasing supply of physicians and other health professionals has reduced the number of health manpower shortage areas, certain sections of the nation may never be able to attract and retain needed health personnel due to economic, social, or environmental conditions. Therefore, AHA supports continued funding both for the National Health Service Corps scholarship and field programs.

Acquired Immune Deficiency Syndrome (AIDS) has been labeled the nation's number-one health priority. As of December 1985, 15,000 cases of AIDS had been reported nationwide, with that number expected to double every 10 to 12 months. The cost of treatment for the first 10,000 AIDS patients has been estimated by the Centers for Disease Control at over $1.4 billion. It is imperative that a sustained and reliable federal funding source be available to allow for continued research into a cure for AIDS and to support necessary clinical trials of the drugs resulting from that research. However, since the first vaccine is not expected to be available for testing until 1988 at the earliest, increased resources must be targeted for education and risk-reduction programs in an effort to slow the spread of the AIDS virus. Additionally, funding should be made available for demonstration projects to explore alternative health care delivery systems for AIDS patients.

The Administration's 1987 budget includes $203 million to support epidemiological studies and investigations, research on causes and cures, and preventive education for AIDS. However, considering the epidemic proportions of the AIDS crisis, AHA believes funding should be continued at least at the FY 1986 appropriated level of $244 million.

The Administration budget includes a request of $957 million for Fiscal Year 1987 for Medicare contractors. Medicare beneficiaries submitted 31 million more claims in FY 1986 than in FY 1985. But Medicare contractors are operating with $12 million less than in FY 1985. To deal with this shortfall the Health Care Financing Adminstration is not providing funds to process all claims, and large backlogs of unprocessed claims are growing. The American Hospital Association supports funding for Medicare contractors at a level of $1.147 billion. These funds are needed to prevent any further backlog.

The American Hospital Asssocation is also concerned with the proposed cuts in programs affecting persons with mental disorders, alcoholism, and substance abuse problems. There are several programs in particular that we would like to comment on. AHA favors the awarding of 425 new and competing extramural research grants at the National Institute of Mental Health, for initiatives in schizophrenia and elderly and child mental disorders. In addition, we recommend an appropriation of $576 million for the Alcohol, Drug Abuse and Mental Health Block Grant, (ADAMHA), and $5 million for state interagency planning grants. A significant portion of the funds would be used by states to provide community mental health intervention services for homeless persons with mental illness. AHA also supports funds for the National Instutite for Alcohol Abuse and Alcoholism (NIAAA) to maintain program growth and restore inititatives such as the National Clearinghouse for Alcohol Information.

AHA supports the $3.4 million appropriation request of the Prospective Payment Assessment Commission for FY 1987. This level of funding is necessary to support research requirements. A significant portion of these funds would be spent on studying the impact of the prospective payment system on the Amercian health care system. The work of PROPAC is vital to assuring the continued high quality of health care for this nation.

TUESDAY, APRIL 29, 1986.

MEDICARE, NHSC, AIDS, PROPAC

WITNESS

WILLIAM S. CONN, JR., PRESIDENT, KENTUCKY HOSPITAL ASSOCIATION

Mr. NATCHER. Our next witness is Mr. William S. Conn. Come around, Mr. Conn. We are delighted to have you before the committee. We will be pleased to hear from you.

Mr. CONN. Thank you, Mr. Chairman. My name is William Conn, and I am President of the Kentucky Hospital Association, headquartered in Louisville, Kentucky. Our Association represents 114 of 123 hospitals who provide health care services to citizens of our commonwealth. I thank you for your kind invitation, Mr. Chairman, to be here today as a guest to appear before you and your distinguished colleagues.

Although I have presented a written statement for the record, I would like to just verbally address three serious problem areas that relate to the Department of Health and Human Services, and specifically the Health Care Financing Administration. They are (1) the level of care determinations being made by Medicare fiscal intermediaries, and (2) medical indigency in our State, and (3) HCFA's pursuit of arbitrary numerical objectives through their peer review organizations.

In order for hospitals to successfully manage under a DRG payment system and to assure that patients receive the appropriate level of care when the patient is ready to be discharged from the acute care setting. Specifically, I reference the need of Medicare beneficiaries to have access to SNF care.

In Kentucky, Medicare patients are being denied access to needed SNF care because our fiscal intermediaries are applying stricter interpretations of the Federal regulations governing SNF services and, thus, increasingly denying SNF service availability to Medicare beneficiaries. As an example, Blue Cross/Blue Shield of Kentucky, who serves as the intermediary for the majority of SNFs in our State, has not only used broad discretion in interpreting Federal coverage criteria, but on several occasions has used coverage determinations which were subsequently overturned by HCFA.

Further, there are inconsistent interpretations of coverage requirements between the two fiscal intermediaries that service Kentucky, as well as among intermediaries in other States surrounding Kentucky.

When patients are denied access to skilled care, they must either remain in the hospital until they can be discharged home or wait long periods of time for intermediate care placement, for which there are long waiting lists due to a shortage of intermediate care beds brought about by a moratorium in our State for the past five years.

Given our State's extreme shortage of long-term care beds and resulting placement problems, we presented our legislature with a proposal of hospital dual licensure whereby a growing number of vacant hospital beds can be utilized for both acute and long-term care. Dual licensure will maximize existing resources and save scarce dollars that otherwise would be necessary for new bricks and mortar construction of long-term care facilities. We believe this innovative dual licensing legislation recently passed by our State legislature and signed into law by Governor Martha Layne Collins could become a model for other States across the country.

In summary, we need relief from HCFA to assure that Medicare patients in Kentucky are not denied access to their skilled nursing benefits and, thus, restricted from being able to access these newly available dual licensed beds as a result of continued rigid interpretations of coverage imposed by our intermediaries, both Blue Cross and Aetna.

Another issue of major concern to our hospitals is the growing number of medically indigent within Kentucky. HHS and the Congress can help States such as Kentucky resolve part of their indigent care problem by refraining from imposing penalties on States that initiate expansion of their Medicaid programs as a means of providing indigent health care services.

Further, in order to enable States to have improved flexibility in addressing the medical care needs of indigent citizens, we urge Congress to separate the medically needy income standards from AFDC payment levels. Elimination of this restriction could enable States such as ours to expand Medicaid coverage to a greater portion of our indigent citizens without otherwise having to bear the enormous financial burden associated with increased AFDC cash payments.

Finally, contrary to the Federal regulations which state that PRO objectives are targets, not quotas, as well as Congressional assurances made by former HCFA administrator, Carolyn Davis, Ph.D., that PROs would not be penalized for failure to achieve numerical objectives, HCFA is now denying contract renewal to PROs where such objectives have not been met.

In Kentucky, as an example, one of our PRO's objectives called for a 7.5 percent reduction in permanent cardiac pacemaker implants. As required by HCFA, all pacemaker insertions were reviewed for medical necessity. However, now our PRO has been denied contract renewal based in part on their failure to meet this arbitrary objective within HCFA's 15-month evaluation period and for each contract quarter, even though the overall objective has been achieved.

This example points out not only that HCFA is failing to live up to previous commitments assuring flexibility of objectives but HCFA actions to enforce these arbitrary objectives could produce serious injurious results. If objectives are not met due to PRO determinations that care provided was appropriate, then HCFA's insistence to enforce absolute compliance leave PROs no choice but to deny medically necessary care and, consequently patients will suffer.

This situation merits Congressional investigation and/or intervention to assure that savings in the Medicare program do not come at the expense of Federal actions to enforce denials of medically necessary care to Medicare beneficiaries.

Thank you, Mr. Chairman, for the opportunity to appear today and present these serious problems.

[The statement of Mr. Conn follows:]

STATEMENT BY

WILLIAM S. CONN, JR., PRESIDENT
KENTUCKY HOSPITAL ASSOCIATION

BEFORE THE HOUSE OF REPRESENTATIVES
COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON LABOR, HEALTH & HUMAN SERVICES,
EDUCATION AND RELATED AGENCIES

TUESDAY, APRIL 29, 1986

Mr. Chairman, my name is William Conn, I am President of the Kentucky Hospital Association, headquartered in Louisville, Kentucky. Our Association represents 114 of 123 hospitals who provide health care services to citizens of our Commonwealth. I thank you for your kind invitation, Mr. Chairman, to be here today as a guest to appear before you and your distinguished colleagues.

I would like to address four serious problem areas that require the attention of the Department of Health and Human Services or the Congress. They are: Level of Care Determination by Medicare Fiscal Intermediaries; Medical Indigency in Kentucky; HCFA Enforcement of PRO Objectives; and Medicare Payment of Capital Costs.

I. LEVEL OF CARE DETERMINATION BY MEDICARE FISCAL INTERMEDIARIES

Since the inception of the prospective payment system, there has been much national concern regarding hospitals discharging Medicare patients "quicker and sicker". I can assure you, however, that premature discharge of Medicare patients is not occuring in Kentucky. To the contrary, our hospitals are experiencing considerable difficulty in securing nursing home placement for Medicare patients.

In order for hospitals to successfully manage under a DRG payment system and to assure that patients receive the appropriate level of care, it is crucial to have adequate access to subacute levels of care upon hospital discharge. However, in Kentucky, hospitals have been unable to place Medicare patients who are in need of skilled nursing facility (SNF) services and, thus, Medicare beneficiaries are being denied access to covered SNF services. This placement problem is a result of what appears to be arbitrary decisions of non-coverage by Blue Cross/Blue Shield of Kentucky which serves as the fiscal intermediary for the majority of SNF's in the state.

The problem with our fiscal intermediary's level of care determinations is threefold. First, patients with medical conditions which were previously covered in a SNF are no longer classified as in need of SNF services. As the federal regulations regarding coverage have remained essentially unchanged since the inception of the Medicare program, our problem with non-coverage appears to have stemmed from stricter interpretations of the regulations by the fiscal intermediary rather than from changes in federal criteria. Second, there is inconsistent interpretation of coverage requirements between the two fiscal intermediaries which service Kentucky as well as among intermediaries in different states. Finally, our intermediary has not only used broad discretion in interpreting federal coverage criteria but, on numerous occasions, has issued coverage determinations which have been overturned by the Health Care Financing Administration (HCFA).

One such illustration involves SNF coverage for nasogastric tube feedings. Our intermediary stated that this condition would only be covered in unusual cases, yet this position was later retracted upon intervention by HCFA that nasogastric tube feedings constitute a skilled service. Recently, however, our PRO advises that a rash of denials have occurred which before were covered. Nowithstanding HCFA's directive that tube feedings be covered and without regard to the apparent medical needs of Kentucky's patients, our intermediary indicated that these denials were based on the fact that Kentucky had a "low denial rate for nasogastric tube feedings."

The federal government's allowance that intermediaries have essentially unbridled discretion to narrowly interpret Medicare coverage criteria and consequently deny access to SNF services is adversely affecting both providers and patients in our state. SNF operators are being denied their share of federal dollars to provide Medicare covered services. Hospitals are restricted from obtaining SNF placement for patients in need of skilled services. Medicare patients are being denied access to necessary care and access to their full array of Medicare benefits. And, since federal regulations require both Medicare and Medicaid to use common medical criteria for coverage of SNF services, arbitrary interpretations of coverage have resulted in thousands of Kentuckians-both Medicare and Medicaid patients-being treated unfairly.

These arbitrary decisions also have a significant impact on our state Medicaid budget. When Medicare patients are denied SNF admission, they generally become classified as in need of intermediate care. When this occurs, it is likely that nursing homes, due to low staffing and reimbursement levels, will refuse admission of these sicker patients which, in turn, creates a backup of patients in hospital beds. Medicare patients that enter an intermediate care facility are either private pay or Medicaid patients, however, with the cost of an intermediate care facility at $1,200 per month, most private pay patients become Medicaid eligible within 13 weeks of admission. When this occurs, our state is faced with an increased financial burden to pay that portion of Medicaid ICF costs for care that should have been received in a skilled nursing facility under the patient's Medicare benefits were it not for restrictions on coverage imposed by the intermediary.

As Kentucky's population ages, restrictions on skilled nursing facility coverage will increase the strains on Kentucky's Medicaid program. Already, 40 percent of Kentucky's Medicaid budget is spent on four percent of the Medicaid recipients--those in skilled and intermediate care facilities. The more this long term care component of our Medicaid budget grows, money will be diverted out of mandatory services that serve the greatest percent of Medicaid recipients and the burden for providing long term care services to our population will be shifted upon the state.

In addition to interpretations of non-coverage for SNF services, Kentucky's nursing home placement problem has been further exacerbated due to a severe shortage of long term care beds in our state. Kentucky has a higher proportion of population which is elderly than the U.S. and our population is aging rapidly. By the year 2000, the number of Kentuckians age 65+ is projected to increase by 54 percent while the number of persons age 85+ will grow by a staggering 157 percent. Despite our aging population, there is a critical shortage of long term care beds throughout the state. For more than five years, Kentucky has had a moratorium on the addition of skilled, intermediate, and personal care beds. This bed freeze has created a severe hardship on hospital's ability to place Medicare patients in nursing homes.

Many Kentucky counties, particularly in the rural areas of our state, lack access to any skilled or intermediate care facilities; and, existing facilities are running at full capacity with extensive waiting lists. Additionally, most nursing homes are unable or unwilling to accept heavier care Medicare patients. When hospitals cannot place Medicare patients in a nursing home, these patients backup in acute care beds and create additional unpaid costs to to hospitals. In 1984, it was estimated that some 13,000 patients had to remain in acute care beds because nursing home placement was not available. This resulted in an estimated additional cost of $35 million to our hospitals that had to be passed on to private patients or recouped through operating reductions.

Given the extreme shortage of long term care beds and resulting placement problems, we presented our legislature with a proposal for hospital dual licensure whereby a growing number of vacant hospital beds can be utilized for both acute and long term care. Specifically, this law will automatically authorize all Kentucky hospitals to obtain a dual license for 25 beds or 10 percent of the hospital's total acute care capacity, whichever is greater, but not to exceed 40 percent of their total licensed capacity to provide skilled or intermediate care services in acute care beds. No certificate of need approval will be required for dual licensure. Dual licensed beds will remain licensed as acute beds and hospitals will be required to meet long term care standards in order to receive an additional license to provide skilled and intermediate care in the acute beds. Dual licensed hospital beds can only be used to provide long term care if there is not a nursing home bed available in the county of residence of the patient or of the hospital or if the patient has been refused nursing home admission. Dual licensure will help sustain many of our small, rural hospitals by allowing them to receive payment for patients that cannot be placed in nursing homes and will benefit the public by maximizing existing resources and saving scarce dollars that otherwise would be necessary for new bricks and mortar construction of long term care facilities. We believe our innovative dual licensure legislation recently passed by our legislature and signed into law by Governor Martha Layne Collins could become a model for other states to address the problem of excess hospital capacity.

In summary, we need relief from HCFA to assure that Medicare patients in Kentucky are not denied access to their skilled nursing benefits and, thus, restricted from being able to access these available dual licensed beds as a result of continued rigid interpretations of coverage imposed by our intermediaries.

II. MEDICAL INDIGENCY IN KENTUCKY

The provision and financing of health care for the medically indigent is one of the most critical issues faced by Kentucky's hospitals. With a total population of 3.7 million, is has been estimated that in excess of 600,000 Kentuckians have no form of health insurance whatsoever. Of importance is the fact that our Medicaid program covers less than one-half of all Kentuckians with income below the federal poverty guidelines as our Medicaid income eligibility standards are set about 60% below the federal poverty level.

Kentucky's hospitals have shouldered the burden of providing care to our indigent citizens and are the only health care providers required by state law to provide care without regard to ability to pay. Kentucky community hospitals*, in 1984, provided in excess of $64 million in care to indigents representing an increase of 19 percent from 1983 levels. This $64 million in indigent care represented approximately four percent of hospital revenue with about one percent being accounted for in the provision of charity care required pursuant to a Hill-Burton obligation.

Indigent care not covered by the Medicaid program must be financed through lower provider incomes and profit margins, tax revenues, or cost shifting. Kentucky's growing indigent care burden cannot be subsidized by hospital operating margins which, in 1984, averaged only 1.2 percent. Also, it is nearly impossible to shift these additional unpaid costs in Kentucky's growing competitive health care environment where HMOs are refusing to participate in the financing of hospital indigent care by extracting hospital discounts and seeking to pay only the actual cost of care for their beneficiaries.

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*Does not include Frazier Rehab, Shriners, Cardinal Hill or Humana hospitals

Without relief, many of Kentucky's community hospitals, particularly our small, rural facilities which serve a disproportionately large share of Medicare and Medicaid patients, will be unable to support increasing demands for indigent care. This will lead to reduced quality and accessibility of health care services to our citizens.

A further complication to Kentucky's indigent care problem is the fact that we have the eighth highest unemployment rate in the nation and rank 44th in per capita income. Our economy is also undergoing a shift with a greater percent of our population employed in lower wage service sector jobs with few or no fringe benefits. Thus, while Kentucky has a large percentage of population who are medically indigent yet cannot qualify for Medicaid, our low per capita income creates a hardship on our state's ability to finance the provision of needed health care services to a large and growing number of indigents.

To help states such as Kentucky resolve part of their indigent care problem, we ask your support to refrain from imposing penalties on states that initiate expansion of their Medicaid programs as a means of providing indigent health care.

Further, in order to enable states to have greater flexibility in addressing the medical care needs of indigent citizens, we urge Congress to separate the medically needy income standards from AFDC payment levels. Federal law limits the medically needy income standard to 133% of a state's AFDC payment level. Elimination of this restriction could enable states such as ours to expand Medicaid coverage to a greater portion of indigent persons without otherwise having to bear the enormous financial burden associated with increased AFDC cash payments.

III. HCFA ENFORCEMENT OF PRO OBJECTIVES

Finally, contrary to the federal regulations which state that PRO objectives are targets, not quotas, as well as Congressional assurances made by former HCFA administrator, Carolyn Davis, Ph.D., that PRO's would not be penalized for failure to achieve numerical objectives, HCFA is now denying contract renewal to PRO's where such objectives have not been met. In Kentucky, as an example, one of our PRO's objectives called for a 7.5% reduction in permanent cardiac pacemaker implants. As required by HCFA, all pacemaker insertions were reviewed for medical necessity. However, now our PRO has been denied contract renewal based in part on their failure to meet this arbitrary objective within HCFA's 15 month evaluation period and for each contract quarter, even though the overall objective has been achieved. This example points out not only that HCFA is failing to live up to previous commitments assuring flexibility of objectives but HCFA actions to enforce these arbitrary objectives will produce injurious results. If objectives are not met due to PRO determinations that care provided was appropriate, then HCFA's insistence to enforce absolute compliance will leave PRO's no choice but to deny medically necessary care and, consequently, patients will suffer. This situation merits Congressional investigation and intervention to assure that savings in the Medicare program do not come at the expense of federal actions to enforce denials of medically necessary care to Medicare beneficiaries.

IV. MEDICARE PAYMENT OF CAPITAL COSTS

Another issue of concern to Kentucky hospitals involves the Administration's plan to establish the method for Medicare payment of hospital capital costs by regulation, thereby bypassing Congressional debate and action on the issue. Our preliminary analysis of the Administration's capital plan indicates that many of Kentucky's hospitals will be severely damaged--predominantly those hospitals that have undergone a major rebuilding program in the last five to seven years.

Many of our hospitals have undergone renovation or replacement as has been necessary to provide their communities with state of the art facilities and equipment and to attract and retain medical personnel in the rural areas of our state. The losses to be incurred by these rural hospitals could put these facilities into bond default and force them ultimately to close their doors. Moreover, since Kentucky hospitals fall in the census region where hospitals have had the lowest costs and thus receive the lowest DRG prices in the nation, our hospitals are at a distinct disadvantage in their ability to recoup losses on Medicare capital payment from DRG prices.

In short, we believe that any and all proposals for Medicare capital payment must be fully debated by Congress to adequaltey assess the impact on hospitals as well as continued accessibility to needed health care services.

I have taken the liberty of appending a copy of the hospital dual licensing legislation recently passed in Kentucky for your information.

Thank you.

86 RS BR 2334

IN HOUSE

REGULAR SESSION 1986

HOUSE BILL NO. 982

THURSDAY, MARCH 6, 1986

Representatives Richard A. Turner and Gerta Bendl introduced the following bill which was ordered to be printed.

AN ACT relating to medical assistance.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

Section 1. KRS 205.560 is amended to read as follows:

(1) The scope of medical care for which the cabinet for human resources undertakes to pay shall be designated and limited by regulations promulgated by said cabinet, pursuant to the provisions hereof. Within the limitations of any appropriation therefor, the provision of complete upper and lower dentures to recipients of medical assistance program benefits who have their teeth removed by a dentist resulting in the total absence of teeth shall be a mandatory class in the scope of medical care. Payment to a dentist of any such medical assistance program benefits for complete upper and lower dentures shall only be provided on the condition of a preauthorized agreement between an authorized representative of the medical assistance program and the dentist prior to the removal of such teeth. The selection of another class or other classes of medical care shall be recommended by the council to the secretary for human resources after taking into consideration, among other things, the amount of federal and state funds available, the most essential

needs of recipients, and the meeting of such need on a basis insuring the greatest amount of medical care as defined in KRS 205.510 consonant with the funds available including but not limited to the following categories, except where such aid is for the purpose of obtaining an abortion:

(a) Hospital care, including drugs, and medical supplies and services during any period of actual hospitalization;

(b) Nursing home care, including medical supplies and services, and drugs during confinement therein on prescription of a physician, dentist, or podiatrist;

(c) Drugs, nursing care, medical supplies and services during the time when a recipient is not in a hospital but is under treatment and on the prescription of a physician, dentist, or podiatrist;

(d) Physician, podiatric and dental services;

(e) Optometric services for all age groups shall be limited to prescription services, services to frames and lenses, and diagnostic services provided by an optometrist, to the extent the optometrist is licensed to perform the services and to the extent the services are covered in the ophthalmologist portion of the physician's program. Eyeglasses are provided only to children under age twenty-one (21).

(f) Nonprofit neighborhood health organizations or clinics where some or all of the medical services are provided by licensed registered nurses or by advanced medical students presently enrolled in a medical school accredited by the Association of American Medical Colleges and where such students or licensed registered nurses are under the direct supervision of a licensed physician who rotates his services in this supervisory capacity between two (2) or more of the nonprofit neighborhood health organizations or clinics specified herein.

(2) Payments for hospital care, nursing home care, and drugs or other medical, ophthalmic, podiatric and dental supplies shall be on bases which relate the amount of the payment to the cost of providing such services or supplies. It shall be one (1) of the functions of the council to make recommendations to the cabinet for human resources with respect to such bases for payment.

(3) No vendor payment shall be made unless the class and type of medical care rendered and the cost basis therefor has first been designated by regulation.

(4) The rules and regulations of the cabinet for human resources shall require that a written statement including the required opinion of a physician shall accompany any claim for reimbursement for induced premature births. This statement shall indicate the procedures used in providing such medical services.

(5) The range of medical care benefit standards

provided and the quality and quantity standards and the methods for determining cost formulae for vendor payments within each category of public assistance and other recipients shall be uniform for the entire state, and shall be designated by regulation promulgated within the limitations established by the Social Security Act and federal regulations. The amount of payments for units of services need not be uniform for the entire state but may vary from county to county and from city to city, as well as among hospitals, based on the prevailing cost of medical care in such locale and other local economic and geographic conditions, except that insofar as allowed by applicable federal law and regulation, the maximum amounts reimbursable for similar services rendered by physicians within the same specialty of medical practice shall not vary according to the physician's place of residence or place of practice, so long as the place of practice is within the boundaries of the state.

(6) Nothing in this section shall be deemed to deprive a woman of all appropriate medical care necessary to prevent her physical death.

(7) To the extent permitted by federal law, no medical assistance recipient shall be recertified as qualifying for a level of long-term care below the recipient's current level, unless such recertification includes a physical examination conducted by a physician

licensed pursuant to KRS Chapter 311 or by an advance registered nurse practitioner licensed pursuant to KRS Chapter 314 and acting under such a physician's supervision.

SENATE

KENTUCKY GENERAL ASSEMBLY AMENDMENT FORM

1986 REGULAR SESSION

Page(s) 1 of 5

Amend printed copy of GA Copy of House Bill 982

On page 5, line 5,

By adding the following new sections:

"SECTION 2. A NEW SECTION OF KRS CHAPTER 216B IS CREATED TO READ AS FOLLOWS:

Notwithstanding any provision of this chapter to the contrary, a licensed acute care hospital may, upon meeting appropriate standards as determined by the cabinet, whether or not a capital expenditure is required for the implementation and without certificate of need approval, obtain a dual license for twenty-five (25) licensed acute care beds or ten percent (10%) of the hospital's total licensed acute care bed capacity, whichever is greater, but not to exceed forty percent (40%) of the hospital's total licensed acute care bed capacity, to provide skilled nursing or intermediate care in such beds. No person shall be admitted to an acute care bed for the purpose of receiving intermediate care or skilled nursing care

Amendment No. 2

Committee Amendment

Floor Amendment ✓

Adopted:

Rejected:

Sen. Benny Ray Bailey

Signed:

LRC Drafter: Dianna McClure

Date: March 28, 1986

Doc. I.D.: 2345C

SENATE

KENTUCKY GENERAL ASSEMBLY AMENDMENT FORM

1986 REGULAR SESSION

Page(s) 2 of 5

Amend printed copy of GA Copy of House Bill 982

unless there is not a bed available in any intermediate care facility or skilled nursing facility within the county of residence of the patient or of the hospital or the patient has been refused admission to such intermediate care facility or skilled nursing facility. Dual licensure of acute care beds does not constitute either a substantial change in bed capacity or a substantial change in a health service.

SECTION 3. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

(1) To prevent inappropriate placement and to contain costs related thereto, the secretary for human resources shall implement a statewide prescreening and admissions review system, including the imposition of a resource means test, for all long-term care facilities and beds, as defined under KRS Chapter 216, and any acute care hospital based skilled nursing or intermediate care beds

Amendment No. 2
Committee Amendment
Floor Amendment ✓
Adopted:
Rejected:

Sen. Benny Ray Bailey
Signed: Benny Ray Bailey
LRC Drafter: Dianna McClure
Date: March 28, 1986
Doc. I.D.: 2345C

SENATE

KENTUCKY GENERAL ASSEMBLY AMENDMENT FORM

1986 REGULAR SESSION

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participating under title XIX of the social security act, regardless of the payment status of the resident upon admission. Any person having resources sufficient to cover the cost of care for at least three hundred sixty-five (365) days following admission may be admitted to a long-term care bed or facility if such person so desires; Provided, however, that if a person:

(a) Is admitted to a long-term care facility or acute care hospital based skilled nursing or intermediate care bed without participating in the prescreening and admissions review system; or

(b) Participates in the prescreening and admissions review system and is not authorized for placement in a long-term care facility or acute care hospital based skilled nursing or intermediate care bed;

such person is not eligible for medical assistance payment for skilled nursing or intermediate care for one (1) year after the date

Amendment No. 2

Committee Amendment

Floor Amendment ✓

Adopted:

Rejected:

Sen. Benny Ray Bailey

Signed: Benny Ray Bailey

LRC Drafter: Dianna McClure

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of the person's admission to a skilled nursing or intermediate care facility or acute care hospital based skilled nursing or intermediate care bed unless the person subsequently participates in the prescreening and admissions review system and is authorized for admission to an intermediate care or skilled nursing facility or acute care hospital based skilled nursing or intermediate care bed.

(2) To implement the provisions of this section the cabinet shall establish preadmission screening teams composed of a nurse, social worker and physician.

(3) Before pre-authorization of any person for admission to an intermediate care facility or skilled care facility or acute care hospital based skilled nursing or intermediate care bed, the cabinet shall first make the following determinations:

(a) The health status and care needs of the person requires immediate institutionalization in an intermediate care facility or

Amendment No. 2

Committee Amendment

Floor Amendment ✓

Adopted:

Rejected:

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skilled nursing facility or acute care hospital based skilled nursing or intermediate care bed;

(b) The person and his family have been fully advised of alternatives to institutional care and possible sources of reimbursement for such care;

(c) Alternatives to institutional care are not feasible; and

(d) Other such determinations as specified by administrative regulations promulgated by the cabinet under KRS Chapter 13A.

(4) Admission of a person to an intermediate care facility, or a skilled nursing facility without first obtaining prior authorization from the cabinet for human resources shall constitute a Class B violation.

(5) The secretary for the cabinet shall promulgate such administrative regulations, subject to KRS Chapter 13A, as necessary to implement this section."

Amendment No. 2	Sen. Benny Ray Bailey
Committee Amendment	Signed: Benny Ray Bailey
Floor Amendment ✓	LRC Drafter: Dianna McClure
Adopted:	Date: March 28, 1986
Rejected:	Doc. I.D.: 2345C

Mr. **Natcher**. Thank you very much, Mr. Conn. You have made an excellent statement and we appreciate your appearance.

At this point we will insert in the record the statements of Mr. Michael Casserly representing The Council of the Great City Schools and the statement of Mr. Gregory A. Humphrey representing the American Federation of Teachers.

[The statements of Messrs. Casserly and Humphrey follow:]

STATEMENT OF GREGORY A. HUMPHREY, DIRECTOR OF LEGISLATION AMERICAN FEDERATION OF TEACHERS, AFL-CIO BEFORE THE SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES AND EDUCATION, OF THE COMMITTEE ON APPROPRIATIONS

April 29, 1986

Mr. Chairman, Members of the Committee:

Thank you for the opportunity to appear today and offer the views of the American Federation of Teachers on education appropriations for Fiscal Year 1987. We at the American Federation of Teachers know the Committee has an arduous task and has struggled hard to provide adequate funding for federal education programs. I'd like to express our appreciation for your continuing efforts to maintain the important federal role in education. At the outset I would also like to express our strong opposition to funding cuts proposed by the Reagan Administration. In particular we must speak against the proposed one-half cut in Vocational Education, elimination of Impact Aid B's, elimination of aid to the Virgin Islands, and wholesale cuts in higher education student aid.

Several years ago we applauded the report, A Nation At Risk, which documented the great need for educational renewal in the United States. Mr. Chairman, our nation continues at risk! This, in part, is due to a shrinking federal role in education, in real dollars. As a recent Congressional Research Service report shows, when adjusted for inflation federal funds for education programs have decreased by about 16 percent since 1980. Federal education programs now provide only 7 percent of total estimated expenditures for education in the United States. The AFT believes Congress must act now to reverse the trend of unilateral disarmament in education. We would like to work with you to regain the ground that has been lost in the last half-dozen years.

I mentioned the report, A Nation At Risk, not only because of its dire warning, but because of statements it made on funding priorities. The report said that, based on commission hearings and based on a Gallup Poll, it was clear that Americans wanted education placed at the top of the national agenda. The 1982 Gallup Poll on the Public's Attitudes Toward The Public Schools showed that education was viewed as more important than developing the best industrial system or the strongest military. The public clearly believed that education should be the top priority for additional federal funds. We at the AFT believe the public wanted then, and wants now, a restoration of a constructive federal role in education.

The AFT requests that in its markup of legislation for FY 1987 appropriations, the Subcommittee begin the process of restoring the purchasing power of federal aid to education. An initial, important step would be restoring the funds cut on March 1st of this year by Gramm-Rudman and then adjusting that FY 1986 amount upward for inflation. Our understanding is that this type of increase would require approximately an additional 1.5 billion dollars over current funding.

As much as there is need for a general restoration of federal education programs, some programs call out for special consideration. Chapter One, E.C.I.A., increased in funding nearly 15 percent between FY 1980 and FY 1986. Yet, in constant dollars, funding declined by nearly 24 percent. There has also been a loss of more than one-half million students served. The AFT requests an increase of funding for Chapter One of 500 million dollars in FY 1987 over the FY 1986 level. This would not only restore the March 1st cut and adjust for one year of inflation, but would regain some of the ground lost in number of students served. We believe the excellent record of accomplishment by Chapter One warrants such support.

Federal support for Education of the Handicapped has decreased significantly in real dollars. The federal share of "excess costs" declined from more than 12 percent in FY 1980 to less than 9 percent in the current year. The AFT requests additional funding of 250 million dollars in FY 1987, approximately one-half of the amount needed to return to the 12 percent federal share in paying for federally mandated services. FY 1988 should see the full restoration to the 12 percent level.

Funding of Pell Grants for needy college students has increased more than one-third between FY 1980 and FY 1986. Yet, the amount of costs at a public 4-year institution covered by the maximum grant has declined from approximately 70 percent when the program originated to only about 40 percent at present.

The AFT requests additional funding for Pell Grants in the amount of 370 million dollars for FY 1987. We believe such an increase is reasonable, given the importance of the Pell Grant program as a foundation for needy students to attend college. It would restore the recent cut and shortfall.

The AFT is especially supportive of full appropriations for Talented Teacher Fellowships and the Carl Perkins Scholarship Program. The Perkins Scholarships were funded at approximately one-half the authorized level for FY 1986, but the Administration has yet to release regulations necessary to implement the program. The Perkins Scholarships are modeled on the highly successful R.O.T.C. program, and are, we believe, an important innovation to attract bright students into the rapidly depleting ranks of teaching. Given the delayed start-up and the magnitude of the impending shortage of teachers, full funding of 21 million dollars is justified. The Teacher Fellowships, at a funding level of 2 million dollars for FY 1987, are also justified. These fellowships will provide much needed recognition and encouragement to outstanding teachers.

Mr. Chairman and members of the committee, again thank you for this opportunity to testify. I shall be happy to respond to any questions.

opeiu#2/aflcio

Testimony

on

FY87 Appropriations for Education

before the

Subcommittee on Labor, Health and Human Services
and Education

of the

Committee on Appropriations

U.S. House of Representatives

Presented by

Michael Casserly

The Council of the Great City Schools

April 29, 1986

Washington, D.C.

Testimony on FY87 Appropriations for Education
Presented by the
Council of The Great City Schools

Mr. Chairman, my name is Michael Casserly, Director of Legislation and Research for the Council of The Great City Schools. I am pleased to have this opportunity to testify before this important subcommittee on federal spending for elementary and secondary education programs.

Currently in its 30th year, the Council of The Great City Schools is a national organization comprised of 37 of the nation's largest inner-city public school systems. Our leadership is comprised of the superintendent and one Board of Education member from each city, making the Council the only education group so constituted and the only one whose membership and purpose is solely urban.

The Council's membership serves 4.2 million inner-city youngsters, or about 11% of the nation's public school enrollment. Approximately 32% of the nation's Black children, 27% of the Hispanic children, and 21% of the Asian children are being education in our schools. Almost one-third of our enrollments are of children who reside in families receiving public assistance, and nearly 75% of our average enrollment is minority.

Mr. Chairman, I would like to devote my testimony this afternoon to a review of trends in federal funding for our urban schools since FY80. I would also like to make a number of recommendations to the Subcommittee about FY87 funding.

The 37 urban districts comprising the Council currently receive $1.695 billion[1] from the federal government in this 1985-86 school year, less than a 0.4% increase from the 1980-81 school year. Next school year, the federal allotment to city schools is expected to drop 1.5% because of Gramm-Rudman to a level that is 1.1% below the 1980-81 school year in nominal dollar terms.

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[1] Amount based on data from 32 of the 37 Council districts.

Of the current $1.695 billion, the urban schools receive about $1.113b of it or 65.6% from programs within the jurisdiction of this subcommittee; including $1.043 billion from The Department of Education, $27.4 million from the Department of Labor and $42.6 million from The Department of Health and Human Services. This total amount compares with $1.216 billion from these same sources in 1980-81, down 8.5% mostly as a result of the repeal of CETA. Next year we project that the urban schools will receive about $1.067 billion from programs under the jurisdiction of this subcommittee, down 4.2% from the current school year.

The federal funding that we expect to receive in FY86 (the 1986-87 school year is about 41.8% below what we received in FY80 when we correct for inflation. Funding through The Department of Education is down 32.8%, The Department of Labor is down 90.1% and through The Department of Health and Human Services down 48.8%--see Table 1).

If we look only at The Department of Education funds, then we see that the urban school share of federal elementary and secondary school funds has gone from 13.96% in FY80 to 13.59% in FY86. That the urban school share has not declined is due in part to The Chairman's commitment to both Chapter 1 and the new **Magnet** schools program. For this, Mr. Chairman, we are most grateful.

Table 1. Urban School Loss in Funding From Various Federal Agencies, 1980-1986

Department	Nominal Dollar Change	Inflation Corrected Dollar Change
Department/Education	+ 1.4%	- 32.8%
Department/Labor	- 85.1	- 90.1
Department/HHS	- 22.8	- 48.8
Totals	- 8.5%	- 41.8%

Our current data, which we would be happy to share with The Chairman, indicate this loss in purchasing power has not been made up through either on improved economy or state/local/private sources as The Administration has contended. In fact, the recent educational reform movement appears to be so general in nature as to miss the specialized needs of the urban or rural poor and so inadequate as to fail to offset federal losses. In addition, The Department of Education's hostility to public education, particularly in urban areas, is such that any hope of future federal help is being squelched.

One final point: recent Department of Education testimony left the erroneous impression that upwards of 80% of eligible Chapter 1 children are receiving services. A careful examination of the data shows that maybe as few as 31% but certainly no higher than 45% (depending on how counts are made) of eligible children receive needed Chapter 1 services. No matter how counts are made, however, it is clear that Chapter 1 has lost about 600,000 children since FY80. In inflation corrected terms, the program's funds are down about 28.2% since that time. Furthermore, many LEAs continue to lose funding because of the mandatory switch to the 1980 Census for funds distribution, and the program has been made dramatically more expensive because of the recent Aguilar v. Felton case. And finally, the substantial increase in the numbers of poor children in the nation since 1979-80 has left a much larger pool of eligible recipients without service.

Mr. Chairman, we recommend that Chapter 1 be increased in either an FY86 supplemental or in FY87 by at least $350 million in order to meet these important needs.

One additional program deserves mention: the Magnet Schools Assistance Act. This important program is currently serving 44 grantees to establish and operate magnet school programs in urban areas and small towns. There is every indication as we move into the second year of the program that the legislation is working exactly as intended. We understand that The Department of Education will reopen FY87 funds for new competitions. We urge the Subcommittee to permit such competitions to include both old and new competitors on an equal basis.

Mr. Chairman, we recommend that the Magnet Schools program be funded in FY87 at a level of $75.0 million.

Finally, Mr. Chairman, we would like to recommend that the Impact Aid Bs be provided at least as much funds in FY87 as in FY86.

That concludes our testimony. I would be happy to answer any questions. Thank you very much.

Program-By-Program Federal Budget Allocations To Great City Schools

1980-81 to 1987-88
(FY80 to FY87)

	FY80	FY85	FY86	FY86	FY87	FY87
Department of Education						
Chapter 1 (Part A)	$ 579,302,171	$ 707,252,832	$ 707,252,832	$ 676,840,960	$ 720,767,538	$ 648,690,784
Migrants	2,339,387	2,958,726	2,958,726	2,831,500	2,265,200	2,038,630
Handicapped	9,740,237	12,593,907	12,593,907	12,052,369	12,593,907	11,334,516
Negl./Del.	1,183,097	1,827,217	1,827,217	1,748,647	1,827,217	1,644,495
St. Admin.	225,000	225,000	225,000	215,325	225,000	202,500
Chapter 2	135,572,407	60,596,623	60,596,623	57,990,968	60,596,623	54,536,960
Handicapped Education	76,323,898	84,666,687	90,407,088	86,519,583	83,529,545	75,176,590
Vocational Education	58,191,952	45,367,612	45,367,612	43,416,805	21,790,894	19,611,805
Adult Education	14,764,909	13,004,626	13,004,626	12,445,427	13,009,205	11,708,284
Bilingual Education	31,257,555	24,095,815	24,095,815	23,059,695	24,759,195	22,283,275
Indian Education	3,405,084	2,882,042	2,882,042	2,758,114	2,758,114	2,482,303
Impact Aid	61,486,090	24,623,861	24,623,861	23,565,035	3,100,000	2,790,000
Follow Through	7,983,980	1,016,537	762,403	729,619	0	0
Magnet Schools	--	50,955,603	50,955,603	48,764,512	50,955,603	45,860,043
Math/Science Education	--	6,227,798	2,802,509	2,682,001	0	0
Immigrant Education	--	(2,380,000)	(2,380,000)	(2,277,660)	0	0
Civil Rights IV-A	2,405,951	0	0	0	0	0
Career Education	326,203	0	0	0	0	0
Law Education	679,708	0	0	0	0	0
Women's Equity	292,703	187,151	187,151	179,104	0	0
Alcohol/Drug	695,000	484,665	484,665	463,824	484,665	436,199
Other[2]	102,300	1,467,485	1,467,485	1,404,383	750,000	675,000
Subtotal	$ 986,277,632	$1,042,814,187	$1,044,875,165	$ 999,945,533	$ 999,412,706	$ 899,471,435
Department of Agri.						
Child Nutrition	$ 462,546,662	$ 564,879,124	$ 586,394,530	$ 586,344,530	$ 531,418,400	$ 531,418,400
Nutrition Education	233,671	15,000	0	0	0	0
Subtotal	$ 462,546,662	$ 564,894,124	$ 586,344,530	$ 586,344,530	$ 531,418,400	$ 531,418,400
Department of Labor						
CETA/JTPA	$ 176,578,214	$ 27,433,690	$ 27,433,690	$ 26,254,041	$ 13,599,788	$ 12,239,809
Subtotal	$ 176,578,214	$ 27,433,690	$ 27,433,690	$ 26,254,041	$ 13,599,788	$ 12,239,809
Department of Energy						
Conservation Grants	$ 3,472,817	$ 892,983	$ 889,488	$ 851,240	$ 0	$ 0
Subtotal	$ 3,472,817	$ 892,983	$ 889,488	$ 851,240	$ 0	$ 0
Department of HUD						
Community Developmt.	$ 4,074,289	$ 2,595,603	$ 2,331,385	$ 2,231,135	$ 1,586,336	$ 1,427,703
Subtotal	$ 4,074,289	$ 2,595,603	$ 2,331,385	$ 2,231,135	$ 1,586,336	$ 1,427,703
Department of HHS						
Title XX Day Care	$ 17,530,628	$ 14,608,208	$ 14,608,208	$ 13,980,055	$ 14,608,208	$ 13,147,387
Headstart	16,690,485	21,490,460	21,490,460	20,566,370	21,490,460	19,341,414
Refugee Aid[1]	18,607,952	(6,500,000)	(6,500,000)	(6,220,500)	0	0
Subtotal	$ 52,829,065	$ 42,598,668	$ 42,598,668	$ 40,766,925	$ 36,098,668	$ 32,488,801
EPA						
Asbestos Detection*	$ --	$ 2,687,951	$ 2,687,951	$ 2,572,369	$ 0	$ 0
Subtotal	$ --	$ 2,687,951	$ 2,687,951	$ 2,572,369	$ 0	$ 0
Other						
Corp. Pub. Broadca.	$ 1,500,118	$ 1,564,409	$ 1,564,409	$ 1,497,139	$ 1,355,962	$ 1,220,366
Miscellaneous	1,856,453	9,930,120	9,847,230	9,388,225	692,979	662,889
GRAND TOTALS	$1,689,135,250	$1,695,411,735	$1,718,572,516	$1,669,860,137	$1,584,164,839	$1,478,889,403

*Includes both grants and loans

[1] Includes Cuban Refugee Aid

[2] Includes Reading is Fundamental, NIE grants, Arts in Education, BEOGs, Secretary's Discretionary grants, National Diffusion Network

[3] Includes National Endowment for the Arts, National Endowment for the Humanities, ACTION, ROTC, Johnson/O'Malley, Drivers' Education, Smoking Prevention, Pregnancy Prevention and others.

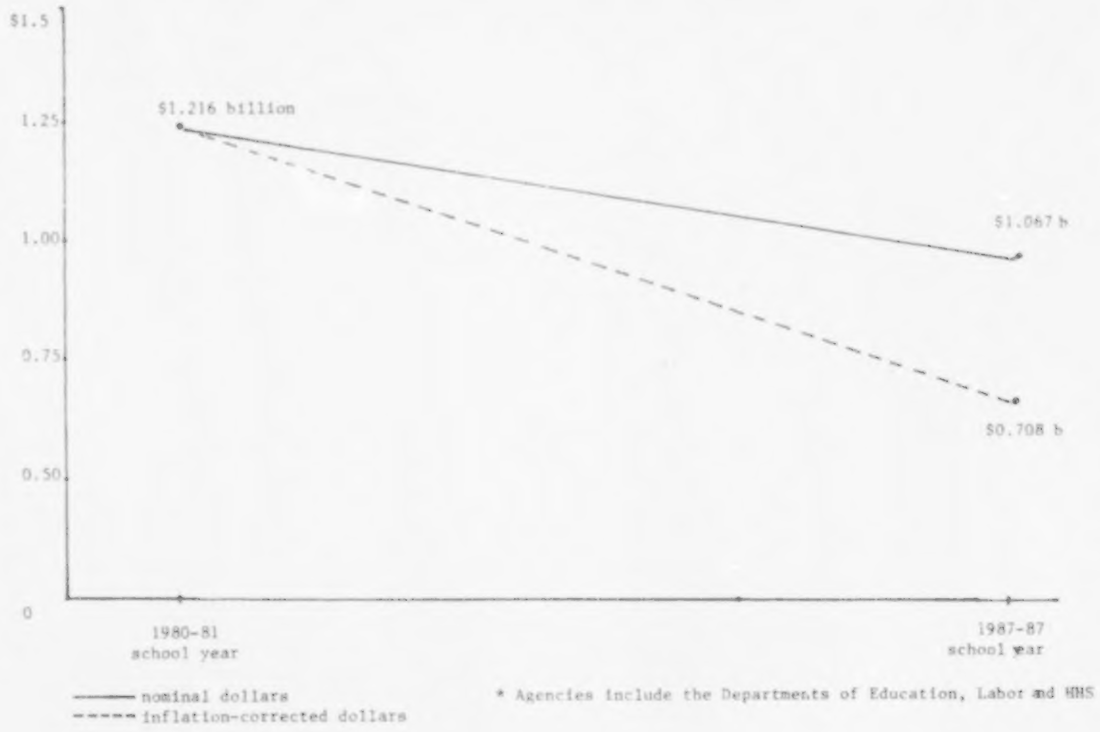
Estimated Federal Revenues To Great City Schools*

	Actual FY80	Actual FY85	Pre Gramm-Rudman FY86	Post Gramm-Rudman FY86	Reagan Proposed FY87	10% Gramm-Rudman FY87
Albuquerque	$ 15,996,218	$ 17,416,882	$ 17,730,411	$ 17,235,805	$ 16,148,493	$ 15,128,544
Atlanta	30,009,802	29,482,366	29,921,920	29,151,326	26,725,973	25,053,377
Baltimore	62,840,099	47,200,286	48,462,512	46,992,295	44,918,878	41,626,990
Boston	30,803,720	31,996,714	32,364,474	31,329,870	27,662,672	25,645,505
Buffalo	25,521,604	29,746,499	30,198,012	29,276,652	27,917,182	25,875,465
Chicago	182,201,840	200,667,113	203,267,730	197,437,722	192,766,516	179,689,865
Cincinnati	17,869,074	17,679,600	17,948,690	17,449,387	16,389,203	15,330,288
Cleveland	N/A	N/A	N/A	N/A	N/A	N/A
Columbus	25,010,688	23,130,154	23,426,466	22,751,544	21,570,266	20,103,240
Dade County	80,147,699	78,407,157	79,839,581	77,785,919	67,189,547	63,320,592
Dallas	34,140,269	35,243,017	35,778,187	34,886,919	33,019,395	31,067,455
Denver	21,282,522	20,248,599	20,481,407	19,860,371	18,843,139	17,528,825
Detroit	90,084,171	76,500,872	77,209,435	74,726,335	72,895,496	67,305,946
Fresno	N/A	N/A	N/A	N/A	N/A	N/A
Indianapolis	N/A	N/A	N/A	N/A	N/A	N/A
Long Beach	13,690,607	19,354,312	19,655,606	19,143,791	17,533,676	16,470,308
Los Angeles	187,410,277	174,635,368	177,649,262	173,988,180	165,810,013	158,029,012
Memphis	37,464,275	38,035,225	38,745,855	37,808,909	35,010,731	33,009,658
Milwaukee	34,797,799	34,567,568	34,948,055	33,869,310	33,641,090	31,206,981
Minneapolis	13,397,485	12,657,632	12,787,175	12,404,986	11,422,762	10,640,486
Nashville	14,774,921	14,956,845	15,183,720	14,759,888	13,608,601	12,753,740
New Orleans	31,100,757	36,017,507	36,437,667	35,361,820	30,991,829	28,842,646
New York	389,832,270	442,070,023	448,052,385	435,096,799	419,557,061	390,809,755
Norfolk	16,350,218	15,549,719	15,811,457	15,291,663	12,726,454	11,953,809
Oakland	N/A	N/A	N/A	N/A	N/A	N/A
Omaha	N/A	N/A	N/A	N/A	N/A	N/A
Pittsburgh	24,756,132	23,176,293	23,389,589	22,597,171	22,261,507	20,506,856
Philadelphia	113,491,472	101,842,856	102,720,695	99,249,420	95,935,056	88,245,550
Portland	15,172,024	13,523,897	13,713,897	13,257,296	12,774,635	11,791,172
Rochester	17,128,858	17,562,261	17,758,602	17,163,466	16,382,253	15,104,126
San Francisco	22,873,022	20,104,806	20,389,655	19,803,018	17,490,394	16,368,859
Seattle	20,801,028	18,051,126	18,235,384	17,446,297	16,905,242	15,644,418
St. Louis	35,826,013	28,190,331	28,540,589	27,826,593	26,573,033	24,989,970
St. Paul	14,146,076	11,433,838	11,594,202	11,217,056	10,866,590	10,044,931
Toledo	12,195,497	12,970,184	13,235,785	12,907,041	12,086,837	11,368,152
Tulsa	7,707,524	8,513,748	8,669,746	8,408,531	8,309,511	7,725,059
Washington	50,311,209	43,928,937	44,427,365	43,174,757	38,230,804	35,707,723
Totals	$1,689,135,250	$1,695,411,735	$1,718,572,516	$1,669,860,137	$1,584,164,839	$1,478,889,403

*All Federal Department Sources; data reported in nominal dollars

Compiled by The Council of The Great City Schools

FUNDING TO URBAN SCHOOL SYSTEMS FROM PROGRAMS WITHIN THE JURISDICTION OF THE SUBCOMMITTEE ON LABOR/HHS/EDUCATION, FY80-86*



* Agencies include the Departments of Education, Labor and HHS

TUESDAY, APRIL 29, 1986.

EDUCATION PROGRAMS

WITNESS

MARY W. LOWE, PRESIDENT, FORT KNOX, KENTUCKY, TEACHERS ASSOCIATION

Mr. NATCHER. Our next witness is Mary Lowe.

You were here yesterday. You are real patient. You are back with us today and we will be pleased to hear you.

Mrs. LOWE. Mr. Chairman and Members of the subcommittee, as has been stated by Mr. Natcher, my name is Mary Lowe of Hodgenville, Kentucky. My city's name may be more familiar to you because it is the birthplace of an outstanding American, the 16th President, Abraham Lincoln. I am pleased to appear here today at the invitation of Congressman Natcher, your chairman. I am a constituent of his and I, along with the Second District of Kentucky, as well as Kentuckians all over, am proud to be represented in these hallowed halls by such a gifted parliamentarian and all-around statesman.

By position, I am a teacher in the Fort Knox community schools, and I am also President of the Fort Knox Teachers Association. Our school is located on the military reservation at Fort Knox. It has an enrollment of approximately 4,000 students, and employs some 500 certified and support employees. Our school system is presently being funded by the Department of Defense.

A few months ago, in December to be exact, our school community, the military families, the surrounding districts and we the employees, became horrified at the thought of the proposed transfer of the Fort Knox schools to the surrounding school districts, and those districts being the two counties of Hardin and Meade. Therefore, we have come here today to urge this committee to keep the Section 6 schools open, and to take them from the Department of Defense and place them under your committee, the Department of Education, for funding. We believe this could be done very smoothly, since such was the cases up until 1981.

Gentlemen, to permit the Section 6 schools to close would cause great stress to the military child, the school districts that would have to absorb the military children, and to all of the employees involved.

The State of Kentucky has taken some great strides toward making some reforms in education, as evidenced by our State legislature and our Governor, but school officials in the counties are Hardin and Meade, which would have to provide educational service to the children at Fort Knox, have told us—and we have documented their statements—that their districts could not absorb an additional 4,000 students.

Upon comparing the services that Fort Knox schools offer, you can readily see—and I have spelled them out in our statement for the official record—that a transfer would cause a loss of all those services as they presently exist. You see, sirs, our curriculum is geared toward the transient life-style of the military family. We offer such programs as speech therapy; we have in-house nurses in each building; we have classes for handicapped; the emotionally disturbed; guidance and counselors; and many other services, but I have merely named a few.

Due to a lack of funds, the two counties that would have to absorb our school system would not be able to provide programs comparable to those offered within our district. Both districts that would be affected by such a transfer are experiencing overcrowded conditions in the classroom, without any foreseeable funds for construction.

My question is: Can 4,000 students at Fort Knox receive comparable education? And any reasonable person can certainly say an astounding No.

Therefore, sir, we, the 500 employees at Fort Knox, are very concerned about the obvious negative effect the transfer would have even on our own employment and benefits, and especially when it comes to retirement. It would appear to us that if such a transfer would take place, at best we would have a dual retirement program, and such a situation would automatically create a unique plan, and one by which we, the employees, would certainly be the losers.

You see, sir, 2 percent of our staff has 30 years of experience, 16 percent of our teaching staff has over 20 years of experience, but they are less than 60 years old, and we have not been able to determine by the Federal retirement system as it exists now as to whether those with 20 years of service or more, but less than 60 years old, would be able to qualify to retire with appreciable benefits at all.

However, we could transfer to the Kentucky retirement system, but if we did so, especially the teachers with 20 years of service or more, but less than 30, they would lose the number of years that they would transfer into the State of Kentucky's retirement plan. By law, the plan in Kentucky states that you may bring in 10 years of service, but if you do so, you lost 10 years of credit in another retirement system. And even suppose, sir, if we were to carry 10 years of service into the State retirement system, it would cause us to have to raise between $20,000 and $30,000 to compensate the Federal retirement system.

I think from what I have said here, you can readily see that any proposed change at Fort Knox would have a great negative impact not only on the students but on the teachers and all the employees.

Nearly 73 percent of our staff has at least a master's degree, and school systems with limited funds tend to hire teachers with less training and less experience, at a lower rate of pay. Therefore, it would be very difficult for the surrounding counties to absorb the students and the teachers at Fort Knox.

Sir, I am going to close by asking you and this committee to insure the Section 6 schools at Fort Knox continue service to the military children by placing the funding of Fort Knox schools into your committee for funding.

Thank you, Mr. Chairman, for the great honor you have given me to come here to address this distinguished subcommittee.

[The statement of Mrs. Lowe follows:]

STATEMENT

Mary D. Lowe, President
Fort Knox (Kentucky) Teachers Association

before the

Subcommittee on Labor, Health and Human Services
and Education Appropriations

3:25 p.m.

Tuesday, April 29, 1986

Mr. Chairman and members of the sub-committee. My name is Mary Lowe of Hodgenville, Kentucky, which, being here, I must mention is the birthplace of Abraham Lincoln.

I am a teacher at Fort Knox, in the school system which is now operated by the Department of Defense for 4,000 children who are dependents of military personnel stationed there, who live on government-owned premises. We are one of the so-called Section 6 schools.

I am also the president of the Fort Knox Teachers Association. We represent the 250 teachers there at Fort Knox.

I am pleased to appear today at the invitation of Congressman Natcher, your chairman. I am proud to be one of his constituents. As the members of this committee know well, I'm sure, the Second District of Kentucky feels it is well represented in these halls by such a knowledgeable and uniquely gifted parliamentarian as Congressman Natcher, one of our nation's great public servants.

I am here as a result of events which began early last December when the Defense Appropriations Act was passed requiring a plan which provided for the transfer of Section 6 schools to the local public school districts in the states where the Section 6 schools now exist.

For the past three months we have been involved in a sort of campaign to convince you ladies and gentlemen of the Congress that to allow the closing of our unique school system and the transfer of our pupils to the local surrounding public school districts would be the wrong direction to take. We are joined in this opinion by our local community leaders back home and by the school boards and superintendents back home in Kentucky who are responsible for the education provided in these surrounding school districts where our pupils would be received if the transfer occurred. We are also supported by education officials in our state who are responsible under the Constitution of Kentucky for providing for the education of the youth of Kentucky.

We are here to urge this sub-committee to consider a provision that Section 6 schools be kept open and be funded under the Department of Education rather than the Department of Defense, as has been true in the recent past. We believe this is the best way to assure that these schools will remain in operation. These schools should remain open and should be funded by the federal government for the reasons which I will now turn to.

The two county school systems who would receive the students from Fort Knox should the transfer occur are Hardin County and Meade County. These counties are fairly typical rural Kentucky counties, although one in particular is experiencing rapid population growth. Their schools are near the middle in any ranking of the 180 school districts in Kentucky in the amount of money they spend per pupil in their educational programs, projected this school year to be approximately $2,100 or $2,200 per pupil per year in both systems. This is only about two-thirds of the nation-wide average of around $3,200. Relative to the nation as a whole, I think statistics would show that these are among the poorer districts in terms of financial support.

On the other hand, the per pupil expenditure at Fort Knox is considerably higher than Kentucky generally and of these two local school districts in particular. In fact, we rank near the national average in this regard. Our program is better financed, better staffed, and for this reason, we believe better able to serve the special needs of our pupils.

Comparison of school districts is a difficult activity, but this will give you a rough idea of the differences between Fort Knox and the others. For example, our school system has 12 guidance counselors, the same number reported by the Hardin County schools whose enrollment is nearly three times the size of ours. We have elementary P.E. teachers, speech therapists, nurses, teachers of emotionally disturbed, and special teachers of gifted and talented pupils. We have 11 reading improvement teachers. All these teachers provide services to our pupils which for the most part are not now available in the surrounding school districts. If the transfer occurs, one can only assume that these are services which will not be available to our students with special needs.

Even the existing programs in these receiving school districts will be watered down as the same resources become spread over more pupils.

Let me also mention the lack of space. In Hardin County where the population is growing, the school population has been increasing by about 500 pupils per year. The schools are now seriously overcrowded and the school district is behind in needed building programs. The administration there told us last week that they needed a $12 million program to be up to standards in classroom space. All they can see coming is only between one and two million recently appropriated by the legislature.

The essential problem of financing education in Kentucky is that the state legislature has enacted statutes which place an artificial cap on local taxes. This has made it difficult or usually impossible for a local school district to raise its local financial support by any significant amount. The only important source would be new taxes at the state level, which up to now, state legislators have been reluctant to consider. Money is tight and despite some recent improvements, as far as we can see now, our state will continue to be among the lower ones in financial support for education.

I came here to mainly raise this question: Can the 4,000 or so Fort Knox pupils receive anything like a suitable education if their schools were closed and they were transferred to the surrounding local school districts?

Given the picture I have described here of declining services and overcrowded classrooms, I think any reasonable person would conclude that the results could only be a steep erosion of educational quality and sharp decline or even disappearance of needed pupil services for not only the Fort Knox pupils but also for those pupils now located in the surrounding local school districts.

I would like now to take up the question of the likely effects such a transfer would have on the employees of the school districts. I want to discuss how our retirement plans, salary and even our job security could be affected.

As employees, we are naturally interested in the effect a transfer of Section 6 might have on our plans for a secure retirement. We are now part of the Civil Service Retirement program like millions of other Federal workers. If the schools are transferred and _if_ our members do become employed by one of the surrounding local school districts, they would have to become contributing members of the Kentucky Teachers Retirement System. They, therefore, will have a complicated problem of having parts of their retirement program in two places, at the state and at the federal level.

I can't say for sure, but I believe that most everyone would lose some retirement benefits caused by the transfer. Perhaps, some a great deal.

Would the possibilities for early retirement help us? Two percent of the teaching staff has 30 years of experience and if they are 55 could now retire. Sixteen percent of the teaching staff has over 20 years of experience and if they are now 60 years could retire. But, early retirement often really means fewer years of work and lower retirement benefits than the employee wanted. This is because fewer years of work provides fewer years of service credit to use in the final calculation of lifetime benefits.

We do not know if the special provision under the Civil Service plan which allows early retirement when service is discontinued will apply in our case. If it did, we could retire early if we have 20 years of service and have reached 50 years of age. But, this latter age provision would eliminate the eligibility of many of the 20 year and above veteran teachers. I am one of these myself.

If our teachers do become employed in a Kentucky school district, they would be benefited by a new statute which was just passed in Kentucky which allows a teacher to purchase retirement credits for up to ten years of teaching out of state. For purposes of the law, Fort Knox teaching would be considered out-of-state teaching. There are some difficult conditions to meet, however.

For one, a Fort Knox teacher cannot purchase credit in the Kentucky system for years which will be used as a basis for any retirement income from Civil Service retirement.

Finally, the cost of purchasing credit for past years of out-of-state teaching would be a hardship for almost all of us. The cost would likely be between 20 and 30 thousand dollars, which we would have to pay in a lump sum to the TRS.

As you see, this issue is complicated and confusing, and although I can't say how much, I think that everyone could lose some benefits, and some a considerable amount.

Leaving retirement concerns, let me now take up the likely effect a transfer would have on our salary. Presently, our salary is determined by making comparisons to salaries paid in five other pre-selected school districts in Kentucky. Being on the edge of the Greater Louisville-Jefferson County metro area, our salaries are somewhat more related to the higher urban area teacher salaries than the more rural, lower paying counties of Meade and Hardin. I will supply your staff with a graph which shows how our current annual teacher salaries relate to those in Meade and Hardin. We are around a couple of thousand dollars higher per annum. Obviously one of the early adjustments we would face is living on less income.

We will also supply your staff with figures which indicate that our support personnel - custodians, cooks, teacher aides, secretaries, etc. - would in some cases experience a considerable drop in salary. Where it was easy for us to draw a comparison, we found that if some Fort Knox school employees were to be paid on the present salary schedule of these local districts, they would receive wage cuts of 25 percent and even some as high as 50 percent.

Let me mention job security. I know my members at home would expect me to bring this up. If the transfer occurs, will we actually have jobs? There may be an opportunity for some negotiations with these two local school boards to work out some kind of fair re-employment process, but whether or not this would occur is not now known. The essential fact is that the present employment of the 463 employees of the school system would be ended. Presumably, those who wished to stay in the area and who wished to stay in education would apply to one or both of the two local school districts.

Even if this happened, we would have to prepare ourselves to accept some more unfavorable changes in our working conditions.

In Hardin County, in placing a newly employed teacher on the salary schedule, recognition is given to only ten years of previous teaching experience in prior employment. Over half of the Fort Knox teachers have over ten years experience, and 16 percent have over 20 years. All these people would end up being placed lower on the Hardin County salary schedule than their years of experience would otherwise determine. This means that about half of our teachers would be assigned a lower status on the salary schedule than their colleagues who had been in the Hardin County system all along. This would be viewed as inequitable and not good for our morale.

A second problem in this regard is likely to be even more serious. Most of our Fort Knox teachers have attained higher academic degrees, making them eligible for placement in a higher rank which provides more pay. Presently 73 percent, nearly three-fourths of our Fort Knox teaching staff has a Masters Degree or some higher degree. Why would school boards whose funds are scarce hire a better trained, more experienced educator when a less experienced, less trained person could be found for less money. Because of this, most of our people could be termed "overtrained" and could face a problem in becoming employed by these local school boards should the transfer occur.

To conclude, I have tried to state the concern of both the employees, the community and the patrons of our school in urging you to seriously consider placing the Section 6 schools in the Department of Education budget where we feel the future of our school system will be more secure.

For nearly 50 years, I am told, our government has been providing schools for the dependents of military personnel at Fort Knox. We go back to the 1930's. The reason has always been that our federal government wanted those who were serving our country in the Armed Services to know that among the sacrifices they were making, one would not find the chance for their dependents to have a suitable education - something comparable to that provided in the rest of the country. It is my belief that what was true then is still true, and that without continuation of Section 6 at Fort Knox, a suitable education program can still not be provided by the surrounding school districts in Kentucky. In saying this, I think I have virtually unanimous consent from everyone affected by this in Kentucky. Thank you, Mr. Chairman, for the great honor you have given me to come here to address this distinguished sub-committee.

Mr. NATCHER. Mrs. Lowe, you have made an excellent statement. We appreciate your appearance.

TUESDAY, APRIL 29, 1986.

EDUCATION PROGRAMS

WITNESS

FRANK E. PERKINS, GRADUATE DEAN, MASSACHUSETTS INSTITUE OF TECHNOLOGY, REPRESENTING ASSOCIATION OF AMERICAN UNIVERSITIES AND THE NATIONAL ASSOCIATION OF STATE UNIVERSITIES AND LAND-GRANT COLLEGES

Mr. NATCHER. Our next witness is Mr. Frank E. Perkins. Come around, Mr. Perkins. You have been patient just like all of these other ladies and gentlemen. Mr. Perkins, we will be pleased to hear from you.

Mr. PERKINS. Thank you, Mr. Chairman.

Members of the subcommittee, I am Frank E. Perkins, Dean of the Grade School at the Massachusetts Institute of Technology. I want to thank the chairman and Members of the subcommittee for this opportunity to testify on behalf of the Association of American Universities, the Association of Graduate Schools, the Council of Graduate Schools, and the National Association of State Universities and Land-Grant Colleges.

I appear before you to present our views on the fiscal year 1987 appropriations for programs authorized by the Higher Education Act. I will focus my remarks on those programs that significantly affect graduate education.

I have already submitted a more detailed written statement of our positions on those programs. My remarks this afternoon will be somewhat briefer and will call attention to specific examples drawn from my personal experience at MIT.

The administration has proposed to eliminate funding for those Department of Education programs of particular importance to graduate education. Yet numerous reports, including the graduate education report of the National Commission on Student Financial Assistance and the recently-issued White House Science Council Report, have documented the link between a strong national graduate education enterprise and such national goals as a vigorous, internationally competitive economy and strong national defense. We hope that the Congress will reject the administration's proposal and sustain the following programs.

1. TITLE IX FELLOWSHIPS

The national graduate fellows program awards fellowships to exceptionally talented students for graduate study in the arts, humanities, and social sciences.

We are grateful to the subcommittee for providing this program's first funding.

I am pleased to state that in the initial competition five fellowships were awarded to students who have chosen to study at MIT.

One of MIT's national graduate fellows is majoring in philosophy, a field in which funding for research support has been particularly difficult to obtain. He has begun a dissertation on cognitive science and the philosophy of psychology, and is regarded in the department as one of their most outstanding students of all time. Yet, he had exhausted all other sources of funding and would not have been able to remain with us to complete his dissertation without the national graduate fellowship.

In order to run a competition next year for a new class of fellows, an increase in funding will be required. An appropriation of $5,000,000 would permit this year's fellows to receive the second year of their fellowship support and allow a new competition for another class of about 200 fellows.

Let me now turn to the graduate and professional opportunities program.

At MIT we currently support 12 minority students under the GPOP program. The study of one of these 12 illustrates the value of the program. This student attended an inner city high school in New York City, and went on to undergraduate study of physics at a leading California university from which he graduated with a C average. Recommendations from faculty members there convinced us that he possessed potential far greater than his grade point average implied. He was admitted to our graduate program in physics and was initially supported at MIT through GPOP. He is now receiving nearly all As, scored near the top in his department's doctoral qualifying examinations, has won a prestigious industry fellowship, and is now looking forward to a faculty career.

We request that this program be provided with an increase in funding for fiscal year 1987 at least equal to the rate of inflation.

The second program I would like to comment on is the Title VII facilities funding.

One of the most serious problems facing our colleges and universities is the pressing need for funds to renovate existing facilities and to construct new facilities.

Even modest programs in combination with other efforts by the Federal and state governments, corporations, and institutions can go a long way toward restoring our outmoded facilities. Accordingly, we hope that you will sustain funding for this program in fiscal year 1987.

The third program I would like to comment on is Title VI international education programs. Recent events in the Middle East and Central America illustrate the continued importance to the nation of knowledge about the language, culture, and customs of our friends and our adversaries. In addition, American business increasingly requires a global perspective.

We request that Congress provide an increase in funding for these programs to permit them to continue operating at their current levels.

The fourth program is the Title II research library funding. Title II-C funding for research libraries represents a small but critically important component of library support.

The library system at MIT has had four II–C grants. One of these involves the conversion to machine readable form of unique holdings in science and technology. These include original works in recombinant DNA, history of computers, energy, et cetera, all of which are being organized, preserved through microfilming, and added to the national data base. Similar projects at other universities are ensuring that important documents are not only preserved, but are made readily accessible to scholars everywhere.

We request that Congress provide an inflationary increase for fiscal year 1987 in the funding for this program.

Finally, Title IV student aid program. I would like to emphasize the importance to graduate students of three programs provided through Title IV: college work-study and the national direct student loan program. We support the testimony of the American Council on Education with respect to both of these programs.

Mr. Chairman, I am convinced that the funds we have asked Congress to provide represent a sound investment in graduate education that will benefit the Nation far in excess of the dollars expended. Thank you for this opportunity to appear before you.

[The statement of Mr. Perkins follows:]

TESTIMONY BEFORE

THE SUBCOMMITTEE ON LABOR, HEALTH, AND HUMAN SERVICES, AND EDUCATION

OF

THE COMMITTEE ON APPROPRIATIONS

IN THE

UNITED STATES HOUSE OF REPRESENTATIVES

CONCERNING

APPROPRIATIONS ON FY 1987 DEPARTMENT OF EDUCATION BUDGET

DELIVERED BY

FRANK E. PERKINS
GRADUATE DEAN
MASSACHUSETTS INSTITUTE OF TECHNOLOGY

ON BEHALF OF

ASSOCIATION OF AMERICAN UNIVERSITIES
ASSOCIATION OF GRADUATE SCHOOLS
COUNCIL OF GRADUATE SCHOOLS IN THE UNITED STATES
NATIONAL ASSOCIATION OF STATE UNIVERSITIES AND
LAND-GRANT COLLEGES

April 29, 1986

Mr. Chairman and Members of the Subcommittee, I am Frank E. Perkins, Dean of the Graduate School at the Massachusetts Institute of Technology. I want to thank the Chairman and members of the Subcommittee for this opportunity to testify on behalf of the Association of American Universities, the Association of Graduate Schools, the Council of Graduate Schools, and the National Association of State Universities and Land-Grant Colleges. I appear before you to present our views on the FY 1987 appropriations for programs authorized by the Higher Education Act. I will focus my remarks on those programs that significantly affect graduate education--the fellowship programs in Title IX, the facilities programs in Title VII, the international education programs in Title VI, and the research library programs in Title II. I will also comment briefly on those programs in Title IV that provide important financial support for graduate students.

The Administration has once again chosen to eliminate funding for those programs of particular importance to graduate education, despite the link that is clear to most between a strong national graduate education enterprise and frequently stated Administration goals of a vigorous, internationally competitive economy and strong national defense. We believe strongly that high quality programs of graduate education are an essential component of the nation's capacity to maintain its leadership position in the world and that the Administration's proposal to eliminate funding for programs important to graduate education will weaken the capacity of the enterprise to maintain its current, internationally recognized level of quality. We hope therefore that the Congress will reject the Administration's request and sustain the following programs.

1. Title IX Fellowships

The National Graduate Fellows Program awards fellowships to exceptionally talented students for graduate study in the arts, humanities, and social sciences. This program has helped restore a measure of balance to the federal commitment to graduate education and has sent an important signal to students and scholars in these disciplines that the federal government recognizes the importance of the highest quality of education and scholarship in all disciplines.

Mr. Chairman, we are most grateful for the action initiated in this subcommittee to provide the first funding for this program in FY 1985. With the $2.5 million provided by Congress in that first year of funding, 30-month fellowships were awarded to 82 exceptionally talented students pursuing graduate study in the arts, humanities, and social sciences at 37 institutions across the country.

I am pleased to state that five fellowships were awarded to students who have chosen to study at MIT. This may surprise some who are aware of MIT's reputation in science and engineering fields. We have long believed that excellence in scholarship requires breadth of scholarship and have pursued a policy directed at sustaining quality of teaching and research across a wide range of disciplines. The importance of breadth as well as depth is one reason we believe that federal policy should have as its objective support for the highest quality of graduate education across all disciplines.

In FY 1986, Congress again provided $2.5 million for this program. Over 1900 applications have been received. With the 4.3% reduction mandated by Gramm-Rudman-Hollings, the Department of Education estimates that 200 12-month fellowships can be awarded for academic year 1986-87.

The authorizing legislation for this program provides for up to four years of support for fellowship recipients. Since the selection process for this highly competitive program has been very rigorous, the attrition rate will be very low. That means that almost all of those who receive fellowships with the FY 1986 funds provided for this program will be submitting applications to renew their fellowships next year. In order to run a competition next year for a new class of fellows, therefore, an increase in funding will be required. An appropriation of $5 million would permit this year's fellows to receive the second year of their fellowship support and allow a new competition for another class of approximately 200 fellows.

I am acutely aware of the pressures on Congress to control spending and recognize that it may seem presumptuous to request an increase in program funding at such a time. Yet the amount we are requesting is quite small. The program serves an important federal purpose, and its implementation by the Department of Education has been quite encouraging. I hope that your subcommittee will be willing to carry forward this promising beginning.

I should like now to turn to the Graduate and Professional Opportunities Program. The GPOP program directly addresses the continued serious underrepresentation of Blacks, Hispanics, and Native Americans in virtually all fields of postbaccalaureate study and the underrepresentation of women in science and engineering fields and in the professions. There is an urgent need to address the problem of underrepresentation of certain groups in graduate education. Minorities make up 21% of the nation's population but receive only 11% of doctorate degrees; Black Americans account for 12% of the population but receive 4% of Ph.D's. Yet, by the year 2000, approximately one in three Americans will be nonwhite. Clearly, both concerns for social justice and practical demands for human capital require attention to this problem.

Elimination of the GPOP program, as the Administration has proposed, would eliminate support for approximately 1400 women and minority students in graduate and professional programs. As an effective vehicle for encouraging students from these groups to pursue the highest levels of academic achievement, the GPOP program clearly warrants continued funding. We request that this program be provided with an increase in funding for FY 1987 at least equal to the rate of inflation.

2. Title VII Facilities Funding

One of the most serious problems facing our colleges and universities is the pressing need for funds to renovate existing facilities and to construct new facilities. New teaching and research requirements, technological changes, justifiable regulations for handicapped access and safety, combine with simple aging to create an enormous demand for facilities renewal. Colleges and universities do not have sufficient funds to meet that demand.

One unfortunate manifestation of the urgent need for facilities funds has been the proliferation of special appropriations requests to address the needs of individual institutions. It is far sounder public policy to address facilities needs systematically through federal programs. Two years ago, this subcommittee recommended the provision of $50 million through Title VII as a first step in providing the Department of Education with resources to assist institutions in addressing the critical facilities problem. That was an important step in reversing a several-year trend of zero funds for facilities. Unfortunately, the FY 1985 funds were reduced in conference to $28 million. For FY 1986, funds were further reduced to $10 million.

No one source of funds can solve the facilities problem, but a combined effort by the federal government, state governments, corporations, and certainly institutions themselves can go a long way toward restoring our outmoded facilities. Accordingly, we hope that you will provide in FY 1987 a level of funding equal to that which was provided for Title VII in FY 1985. Channeled through a single national competition, such funding can contribute significantly to a joint effort to upgrade our campus facilities.

3. Title VI International Education Programs

Since the close of World War II, a large and diverse system of language and area studies programs has grown up on university campuses. The principal stimulus for its development was the growing realization that a global perspective had become more important for the United States and that, as a nation, we needed a reservoir of highly trained specialists knowledgeable about a wide range of countries and cultures.

The international conditions that gave rise to the need for an increased national capacity in foreign language and area studies have only intensified. Economic competition from foreign countries has increased sharply, and our country's balance of payments has plummeted. International tensions continue to rise. Recent events in the Middle East and Central America illustrate clearly the importance of knowledge about the language, culture, and customs of our friends and our adversaries.

It is clearly appropriate for the federal government to support an area of education and research so closely tied to the government's central responsibility for the conduct of foreign affairs and the maintenance of national security. Now is an especially inopportune time to damage our capacity to know more about our friends, competitors, and adversaries abroad.

Admiral B. R. Inman, former Deputy Director of the Central Intelligence Agency and former head of the National Security Agency, stated in congressional testimony:

> My concern has grown as I have watched us become subject to surprise time and again, surprise where we have had insufficient assets applied to problems, and surprise because we did not understand the events that we had some inkling were underway. We have become very good at counting things, and very poor at projecting the challenges that we are likely to face.
>
> I believe increasingly that is a result of the lack of deep understanding of those societies, what motivates them, and how they are changing. The need for scholars inside the government is going to be much greater in the 15 years ahead of us than it has the past 15 years. I believe we are moving into an increasingly hazardous time.

Elimination of funds for Title VI would erase essential support for 93 National Resource Centers, over 800 graduate fellowships, and programs supporting faculty and doctoral dissertation research abroad, as well as programs fostering joint business-university projects to improve international business practices and programs to improve undergraduate instruction in language and area studies.

Because of the central contribution that these programs make to a sound national security, an informed foreign policy, an internationally competitive economy, and enhanced international understanding, we request that Congress provide an increase in funding for these programs sufficient to permit them to continue operating at their current levels.

4. Title II Research Library Funding

Academic libraries are essential for all aspects of university teaching and research. In many disciplines, library collections remain the primary scholarly tool. Rapid changes in technology are revolutionizing the processes by which information is catalogued, stored, retrieved, and distributed. The research libraries of our nation's universities already are national--indeed, international--resources. The technological revolution now underway will create dramatic new possibilities for the sharing of library resources. We will move toward the creation of a unified national library network accessible to scholars on all our campuses, to members of the business community, and to government workers.

Realization of these opportunities, however, places increased demands on the already staggering capital needs of research libraries. Further, in preparing for the future, we cannot afford to neglect the past. We must address the urgent problem of the rapid decay of invaluable and irreplaceable library collections. It is not an exaggeration to say that our intellectual heritage, stored on brittle and crumbling paper, is at risk.

Title II-C funding for research libraries represents a small but critically important component of library support. Since it was first funded in 1978, Title II-C has provided competitively funded grants to libraries for collections development, bibliographic control, and preservation. The competitive nature of the program has assured that grants are provided for well thought-out projects that improve and expand the nation's scholarly resources by strengthening the collections of individual libraries.

Title II, Part C, is a program of proven effectiveness in assisting the nation's research libraries to collect, preserve, and disseminate essential information. We request that Congress provide for FY 1987 an increase in the current funding level of $6 million for Part C equal to the rate of inflation.

5. Title IV Student Aid Programs

I would like to call your attention to the importance to graduate students of three programs provided through Title IV: College Work-Study, the Guaranteed Student Loan program, and the National Direct Student Loan program. We support the testimony of the American Council on Education with respect to these programs. I would only add that College Work-Study provides particularly effective support for graduate students through work such as teaching and research assistance that is closely related to students' educational objectives.

Mr. Chairman, I am convinced that the funds we have asked Congress to provide represent a sound investment in graduate education that will benefit the nation far in excess of the dollars expended. Thank you for this opportunity to appear before you.

Mr. NATCHER. Thank you very much, Mr. Perkins. We appreciate your appearance. You have made a good statement.

TUESDAY, APRIL 29, 1986.

INEXPENSIVE BOOK DISTRIBUTION PROGRAM

WITNESSES

MRS. ELLIOT RICHARDSON, CHAIRMAN OF THE BOARD, READING IS FUNDAMENTAL, INC.

RUTH GRAVES, PRESIDENT, READING IS FUNDAMENTAL, INC.

Mr. NATCHER. Our next witness is Mrs. Elliot Richardson. Come around, Mrs. Richardson. We are glad to have you before the committee today.

Mrs. RICHARDSON. Thank you, Mr. Chairman. It is a pleasure to be here on behalf of Reading is Fundamental. Thank you for this opportunity, and to testify especially on the fiscal 1987 appropriation for the inexpensive book distribution program.

RIF operates this program under contract to the Department of Education.

We thank this subcommittee for all your efforts on behalf of the book program and for the fiscal 1986 appropriation of $7,000,000.

In its fiscal 1987 budget justification, the administration says of the mandated programs, including the book program, "At the present time the Department estimates that it will fund all of the mandated activities at their 1986 enacted levels." We urge this committee to assure adequate funding for the highly successful IBDP by specifying the level at which it is to be funded.

Reading is Fundamental respectfully recommends that the Congress specify a fiscal 1987 appropriation of $7,800,000 to maintain the IBDP at about its current level of services. With a current appropriation of $7,000,000, the book program serves nearly 2,200,000 children. Because book costs continue to rise, as they have done for the last five years, at an annual rate of 11 percent to 14 percent, the increase to $7,800,000 is needed to assure continued services to these more than 2,000,000 young people.

The administration has also, once again, asked the Congress to delete the mandatory wording included, with bipartisan support, in Section 583(b) of the ECIA—wording which provides that from the discretionary fund, the Secretary will first fund the IBDP at least in amounts necessary to sustain the activities at the fiscal 1981 levels.

Congress had sound reasons for including this language.

The mandating wording assures stability through such unpredictable events as the Chicago Case—and through the more predictable changes in administration and Federal agency personnel.

Congress has repeatedly rejected the department's requests to eliminate the discretionary fund mandates. We now respectfully urge the Congress, once again, to reject the Department of Education request to eliminate the mandatory set-asides of Section 583(b).

The IBDP addresses a serious national problem—the growing numbers of young people who can't or won't read. It is clearly less costly to prevent illiteracy than to remedy it once it is entrenched. Reading is a skill and a habit most readily acquired at an early age. The inexpensive book program encourages young people to read often and widely, and it lets them choose books they like—to take home, to keep, and to read.

Since the book program was created in 19876, the program has brought 66,000,000 books into American homes. The program is now reaching youngsters in more than 10,000 locations, through 3,100 local projects throughout the United States and the offshore possessions. The program operates through a grassroots network of some 92,000 community volunteers, 40 percent of them parents.

As a result of their work, evidence mounts that this low-cost program improves:

Children's attitudes toward reading;

The amount of time they read; and

Their use of the library.

It also increases the extent to which their parents become involved in their education.

Typical of the comments we receive from literally thousands of school administrators, teachers, librarians, parents, and others is one from West Point, Kentucky: "Overall reading scores have improved significantly," and "Interest in checking out books has increased noticeably."

From Pittsfield, Massachusetts, we hear: "It is fully documented on all national achievement tests that the reading scores have steadily improved . . . The RIF program contributed to this improvement."

Three recent major studies—the NIE's becoming a Nation of Readers," [the Education Department's "What Works" and the NAEP "Reading Report Card," all undersscore the importance of books in the home, motivating children to read, parental involvement, and independent reading. These are the key ingredients of the book program.

The NIE Report states, for example: ". . . Increasing the proportion of children who read widely and with evident satisfaction ought to be as much a goal of reading instruction as increasing the number who are competent readers . . . an essential step in reaching that goal is providing children ready access to books that interest them."

Because the inexpensive book program

Is a proven means to get young people to read;

Is a low cost, effective way to help prevent illiteracy—

This year the cost is only $3.18 per child;

Addresses a significant national problem;

Offers a means for local citizens and communities to become engaged in the literacy effort—

For every Federal dollar spent, RIF and its projects generate more than $3 in private funds, goods and services;

And is in great demand nationwide: Reading is Fundamental respectfully requests the Congress:

To specify a fiscal 1987 appropriation of $7,800,000 for the Inexpensive Book Distribution Program;

and

To deny the Education Department's request to waive the provisions of Section 583(b) mandating funding of the IBDP.

[The statement of Mrs. Richardson follows:]

Statement for the Record

by

Mrs. Elliot L. Richardson, Chairman
READING IS FUNDAMENTAL, INC.

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for the

Subcommittee on Labor, Health and Human Services, Education
and Related Agencies

House Committee on Appropriations

Regarding:

FY 1987 Appropriations for the Inexpensive Book Distribution Program (IBDP)
Education Consolidation and Improvement Act
Chapter II, Subchapter D, Section 583 (b) (1)

April 29, 1986

STATEMENT OF MRS. ELLIOT L. RICHARDSON
CHAIRMAN, READING IS FUNDAMENTAL, INC.

On behalf of Reading Is Fundamental, I thank you, Mr. Chairman, and this Subcommittee for the opportunity to testify on the FY 1987 appropriation for the Inexpensive Book Distribution Program (IBDP). [Education Consolidation and Improvement Act (ECIA), Chapter II, Subchapter D, Secretary's Discretionary Fund, Section 583 (b) (1).]

This Subcommittee has consistently been in the forefront to assure that our young people are well served by Federal programs. We are particularly grateful for all your efforts on behalf of the Inexpensive Book Distribution Program.

Thanks to the Congress, the Book Program is turning millions of today's youngsters into tomorrow's readers through a grassroots reading motivation program that spans all 50 states and U.S. offshore possessions. Reading Is Fundamental (better known as RIF) has administered the IBDP since Congress created the program in 1976, modelling it on RIF's demonstrated method for preventing illiteracy.

Evidence mounts that this low-cost program achieves remarkable results in improving children's attitudes toward reading, the amount of time they read, their use of libraries, their reading abilities, and their parents' involvement in their education.

READING IS FUNDAMENTAL RECOMMENDS A FISCAL 1987 APPROPRIATION OF $7.8 MILLION FOR THE IBDP

In its FY 1987 budget justification, the Department of Education proposes to increase the Secretary's Discretionary Fund to its $28.9 million FY '86 enacted level, but says of the mandated programs, including the IBDP:

> "At the present time the Department estimates that it will fund all of the mandated activities at their 1986 enacted levels." (Italics ours.)

We respectfully urge this Committee to assure adequate funding for the highly successful

IBDP by specifying the level at which it is to be funded.

Reading Is Fundamental respectfully recommends that the Congress specify a Fiscal '87 appropriation of $7.8 million to maintain the IBDP at approximately its current level of services.

With an appropriation of $7 million, the book program currently serves nearly 2.2 million children with 6,950,000 books. With a fiscal '87 appropriation of $7.8 million we estimate that we could continue to serve between 2.1 and 2.2 million youngsters, assuming that book costs rise no more than 11%. (Experience shows that book prices have risen during the last 5 years at the rate of 11 to 14% per annum.)

Taking into account the inflation rate for books, by the time fiscal 1987 appropriated funds become available to this forward-funded program, level funding at $7 million would result in 400,000 fewer children being served. The increase is needed to assure maintenance in the level of services.

READING IS FUNDAMENTAL RECOMMENDS RETENTION OF WORDING MANDATING FUNDING OF THE IBDP

The Department of Education has once again asked the Congress to delete the mandating wording included, with bipartisan support, in Chapter II, Subchapter D, Secretary's Discretionary Fund, Section 583 (b)(1), which reads as follows:

> (b) "From the funds reserved for the purpose of this section, the Secretary shall first fund -
>
> (1) "The Inexpensive Book Distribution Program (as carried out through 'Reading Is Fundamental')...at lease in amounts necessary to sustain the activities...at the level of operations during Fiscal Year 1981..."

Reading Is Fundamental respectfully urges the Congress to reject the Department's request to override the mandatory set-asides of this section of the ECIA.

Congress had sound reasons for including the mandate. The events of the last two years have revealed just how wise Congress was to do so. It was this mandate which protected the Book Program from serious disruption, and even possible elimination, during the prolonged legal dispute between the Department of Education and the Chicago Board of Education.

It is through such prudent use of its authority that the Congress assures continuity of vital services through unpredictable events such as the Chicago Board of Education suit, as well as through the more predictable changes in administrations and Federal agency personnel.

With equal wisdom Congress has repeatedly rejected the Department's requests to eliminate the Discretionary Fund mandates.

We gratefully acknowledge that much of the Book Program's success is due to the stability Congress provided through the mandating wording.

We now respectfully urge the Congress, once again, to reject the Department of Education request to eliminate the mandatory set-asides of Section 583 (b).

THE IBDP ADDRESSES A CRITICAL NATIONAL PROBLEM

Much can and has been said about the tragic consequences of illiteracy in this country. Here is but a brief recapitulation of findings known only too well to this Committee:

- Six percent of nine-year olds cannot follow the most rudimentary reading instructions, putting them in jeopardy of future school failure.
- Forty percent of 13-year-olds and 16 percent of 17-year-olds have not acquired intermediate reading skills.
- Only five percent of students at age 17 have reading skills required for texts used by professional and technical workers.

- In 1984, the Army spent more that $14...million to bring its recruits up to 9th grade levels in reading.
- Approximately two-thirds of U.S. colleges and universities find it necessary to provide remedial reading and writing courses for students.
- Youngsters with below average reading skills are twice as likely to drop out of school.
- There is a high correlation between illiteracy and unemployment, and illiteracy and crime. It is estimated that three fourths of the unemployed and 60 percent of the prison population are illiterate.

If we fail to instill in our young people the desire to read, our future prosperity, even our future as a democratic society will surely be jeopardized. In an "Age of Information," there are hard times ahead for young people who lack the single most important skill for success -- the ability to read. And there is the real cost to the taxpayer of future remediation, lost productivity, welfare costs, correctional costs.

Without question, the problem becomes more difficult, as well as more costly, the longer we wait.

THE IBDP/RIF METHOD

The most effective and cost-efficient approach to the problem is the prevention of illiteracy. The IBDP is the only nationwide program of its magnitude addressing the issue of preventing illiteracy by reaching young people.

Reading is a skill and habit most easily acquired at an early age, so the IBDP targets its resources to young people, age three through high school. The essence of the program is to expose children to the appeal of reading and let them choose books they like -- to take home, to keep, and to read.

The program is carried out at the community level by a volunteer work force of 92,000 local citizens who make all the important decisions, such as which books to buy, which children to serve, and what activities to use to relate these books to the child's own world. I only wish there were time for me to catalogue the dynamic activities these volunteers devise to make books meaningful to children. As a result of their special efforts, children read widely and develop the knowledge and information so essential to comprehension and to both the basic and higher order reading skills.

Nearly 40 percent of the RIF volunteers are parents. Through their work in the RIF program and through the books their children bring home, millions of parents have awakened to the vital role they can play in encouraging their children to learn and read.

THE IBDP GOES WHERE CHILDREN GO

Thanks to the funding provided through the IBDP, books and a love of reading are reaching children in virtually every type of setting where children congregate: in schools, libraries, migrant worker camps, Indian reservations, day care centers, schools for the handicapped, housing projects, correction centers, programs for non-English speaking immigrants.

This grassroots program is reaching children in some 10,000 locations through more than 3,100 local projects in all the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands and Guam.

The program has been so successful that many other communities nationwide wish to bring it to their children. But, of course, we have been unable to fund new programs for lack of funds

Our mail tells us that with sufficient monies we could easily add 800 to 1,000 new programs, reaching an additional 550,000 to 700,000 more children each year.

Reading Is Fundamental, Inc./6

Since its founding in 1966, RIF has brought approximately 72 million books into American homes. Of that number, 66 million were placed in the hands of America's children through the IBDP.

THE IBDP IS COST EFFECTIVE

It is clearly less costly to prevent illiteracy than to remedy it. This year RIF will reach an estimated 2.2 million young people for the remarkably low cost to the government of only $3.18 per child.

The IBDP also serves as leverage, enabling us to get private funding and to provide additional services to parents nationwide to help them encourage their children to read.

Among the multipliers of the Federal effort are the 8,345 local community businesses and organizations providing services and matching funds; the more than 4,500 work years, or 9.4 million hours donated by volunteers since the IBDP began; the hefty book discounts RIF negotiates on a nationwide scale with 357 book suppliers (most projects purchase books at an average 40 percent discount); and the other aids and services RIF is able to provide to children and local projects. The latter includes a nationwide public education program, nationwide reading campaigns, and workshops and publications for parents. All of these are provided at no cost to the Federal government.

We estimate that because of RIF's unique partnership between the public and private sector, for every $1 of Federal IBDP funds appropriated, Reading Is Fundamental and its local projects leverage about $3.11 in private funds, goods, and services.

STUDIES SUPPORT IBDP/RIF METHOD

Three recent studies have underscored the soundness of the IBDP/RIF approach.

The comprehensive National Institute of Education report, released last Spring, lists prerequisites for a child's development as a reader. Many of these -- books in the home, activities that encourage reading, allowing children to choose their own books -- are key elements of the IBDP/RIF method.

The report states, for example:

> "Reading itself is fun....Increasing the proportion of children who read widely and with evident satisfaction ought to be as much a goal of reading instruction as increasing the number who are competent readers....an essential step in reaching that goal is providing children ready access to books that interest them."

"The Reading Report Card," a National Assessment of Educational Progress study released in September, 1985, again confirmed the correlation between reading matter in the home and children's reading skills:

> "The relationships between available reading material and reading proficiency are as notable as those for level of parental education."

And What Works, a 1986 report from the Department of Education on consistent findings in research about teaching and learning, emphasizes the importance of motivation, parental involvement, reading in the home, and reading widely and often. Of special interest:

> "Children improve their reading ability by reading a lot. Reading achievement is directly related to the amount of reading children do in school and outside."

WITH HELP FROM THE IBDP, CHILDREN CAN AND DO READ

Each year RIF receives literally thousands of reports from school administrators and teachers, librarians, parents and others knowledgeable about local IBDP projects. They report numerous beneficial effects, but certain results are reported with striking consistency.

The most often noted are RIF/IBDP contributions to:

- o Improved attitudes toward reading by the youngsters
- o Children reading more, and becoming increasingly discriminating in their choices of books
- o Parents becoming involved with their children's reading and education
- o Increased library circulation
- o Increased reading achievement

Typical of the comments we receive about RIF is one from West Point, Kentucky:

> "Overall reading scores have improved significantly," and "Interest in checking out books has increased noticeably."

From Pittsfield, Massachusetts, we hear:

> "It is fully documented on all national achievement tests that the reading scores have steadily improved. We feel as parents that the RIF program contributed to this improvement....Children are learning to make reading an accepted part of their daily lives and enjoying it....Parents are behind this program 100 percent."

A study of more than 1,300 youngsters conducted by educational researchers from Tennessee Technological University in Cookeville, Tennessee, concluded that the Reading Is Fundamental approach improved the reading habits of school children and helped them "to translate positive attitudes into active reading" in just one year.

THE IBDP IS AN ECONOMICAL, EFFECTIVE WAY TO PROMOTE LITERACY

Today in 10,000 locations across the nation, RIF volunteers are giving the gift of literacy to millions of young people. For just as illiteracy can be passed from generation to generation, so too can literacy.

If we could but reach one generation of young people -- a generation that would grow up reading, would read to their own children, and instill in the next generation the desire and ability to read -- we might yet break through the cycle of illiteracy.

In a nation as wealthy and concerned as ours, this is not an unreasonable goal.

BECAUSE THE IBDP

- Is a proven means to get young people to read;
- Is a low-cost, effective way to help prevent illiteracy;
- Addresses a significant national problem;
- Offers a means for local citizens and communities to become engaged in the literacy effort;
- And is in great demand nationwide:

READING IS FUNDAMENTAL RESPECTFULLY REQUESTS THE CONGRESS:

- To specify a Fiscal 1987 appropriation of $7.8 million for the Inexpensive Book Distribution Program;

and

- To deny the Education Department's request to waive the provisions of Section 583 (b) mandating funding of the IBDP.

Mr. NATCHER. Thank you very much, Mrs. Richardson. You have made an excellent statement and we appreciate your appearance before the committee. Mr. Conte.

Mr. CONTE. I want to add my personal welcome to Mrs. Richardson. Anne has been a consistent advocate of education in this country, and we take her word very seriously here. In fact, Anne and I recently teamed up to enact "National Reading is Fun Week", which the nation honored last week. Anne, as always, it is enjoyable working with you. You're very successful.

Mrs. RICHARDSON. Thank you. It was great. We really appreciate your taking the lead in that. It was a week celebrated all over this country by communities, and it whipped up a lot of enthusiasm for reading.

Mr. CONTE. Give my best to Elliot.

Mr. NATCHER. Thank you.

TUESDAY, APRIL 29, 1986.

VOCATIONAL EDUCATION

WITNESSES

ROBERT E. TAYLOR, EXECUTIVE DIRECTOR, THE NATIONAL CENTER FOR RESEARCH IN VOCATIONAL EDUCATION, THE OHIO STATE UNIVERSITY

CHESTER HANSEN, SENIOR ASSOCIATE DIRECTOR

Mr. NATCHER. Mr. Robert E. Taylor. Who do you have with you there?

Mr. TAYLOR. I have Chester Hansen with me, Chairman Natcher, the Senior Associate Director at the National Center. We have filed written testimony, but we appreciate this opportunity to highlight some points of it. Before I go further, let me again thank you and Congressman Conte and Congressman Stokes and others that have been very supportive of our efforts to advance the quality and responsiveness of vocational education programs throughout this nation, and for the opportunity to report on the Center.

This is an important year for the National Center, because beginning on January 15, we are operating for the first year under the provisions of the Carl D. Perkins Act. The Act provides for a minimum funding level of $6,000,000 for the Center, changes the procurement mode from a contract to a grant. This change has great significance for a program improvement operation, such as the Center. It provides us the freedom to gather data that enable us and the vocational education enterprise to make data-based decisions in improving programs and guiding policy decisions.

Further, the grant mechanism coupled with the forward funding provision facilitates long-range planning and contributes to efficiency and effectiveness in carrying out our responsibility.

Additionally, I wanted to acquaint you with the recent completion of the mid-contract review of the National Center conducted by the Department of Education. This review was carried out last summer by eight distinguished professionals from education and industry, under the auspices of the department, who spent five days looking at all aspects of our operation, issued a 35-page report, and I want to cite just one sentence: "The National Center is found to be a mature, capable research institution which is providing taxpayers with full value for their money. It is bringing about true improvement in vocational education."

In my testimony today, I just want to highlight that we are responding directly to the priorities established for the Center in the new Act, and are carrying out Congressional intent. Not only are we relating to it, but we had anticipated many of these priorities and already have completed past work.

The Center, as you know, as several functions assigned to it by the Congresss—research and development, evaluation, information for planning and policy, and in addition to the national longitudinal studies that we are conducting to determine the effects and outcomes of vocational education in the labor market, on further education, and so on, we are undertaking this year a new effort, and that is to look at the dynamics of vocational classrooms in 942 places, to look at classroom learning environment in terms of key policy issues such as reinforcement of basic skills, the narrowness or breadth of the occupational focus, teacher preparation, linking academic and vocational equity issues and at risk populations.

Further, we are packaging, if you please, some of our prior work in basic skills to provide a series of interventions to local districts to strengthen basic skills through vocational instruction.

The second package deals with school-to-work transitions, and the third on postsecondary and adult learners.

I don't have time to enumerate all of the other projects that are going on, but I do ant to just point to the outreach of the Center. Last year, through our National Academy that conducts workshops and seminars to implement research and help bring about change and improvement in the vocational education enterprise, we conducted 106 workshops, held them in 50 different States and served over 8600 State and local leaders of vocational education.

Further, the dissemination and utilization function of the Center through the 800 number serviced some 13,000 information requests from local teachers, school board members, local employers, advisory council members, and others.

One of the other critical assignments of the Center by the Congress is to render a report yearly to the Secretaries of Labor and Education and to the Congress on the extent, efficiency and effectiveness of joint planning and cooperation under the Vocation Education Act and JTBA. That study is underway, and the report will be ready in about one year.

To wrap up, just let me say that we appreciate your previous support. We hope that our request for forward funding through an annual grant with a funding level as suggested in the law will be forthcoming, and we would be pleased to answer questions or provide any additional information the committee might require.

[The statement of Mr. Taylor follows:]

STATEMENT BY

Dr. Robert E. Taylor
Executive Director
The National Center for Research
in Vocational Education
The Ohio State University

Presented to

The United States House of Representatives
Committee on Appropriations
Subcommittee on Labor, Health and Human Services,
and Education

April 29, 1986

STATEMENT TO

The United States House of Representatives
Committee on Appropriations
Subcommittee on Labor, Health and Human Services,
and Education

April 29, 1986

Thank you, Chairman Natcher and members of this subcommittee, for your continued support of our efforts to advance the quality and responsiveness of vocational education programs throughout the nation, and for this opportunity to report on the National Center.

This is an important year for the National Center. Beginning on January 15, we are operating under the first year of the provisions of the new Carl D. Perkins Act. The Act provides a minimum funding level of $6,000,000 for the National Center and changes the procurement mode from a contract to a grant. This has great significance for a program improvement operation, such as the National Center. It provides freedom to gather data that enable us and the vocational education enterprise to make data-based decisions in improving programs and guiding policy decisions. The grant mechanism facilitates longer range planning.

Additionally, last summer we completed a mid-point review and evaluation conducted by the Department of Education. This review was carried out by eight distinguished professionals from education and industry, serving as external reviewers for a period of five working days at the National Center. The review panel found the "National Center to be a mature, capable research institution which is providing taxpayers with full value for their money. It is bringing about true improvement in vocational education ..."

In my testimony today, I want to show how the National Center is responding directly to the priorities for the National Center in the Act and carrying out Congressional intent. Our current projects and activities focus on those priorities established in the statute. I also want to point out the degree to which we were already engaged in many activities relating to the priorities of the new Law. Finally, I want to make a special plea for retaining the forward-funding provisions for the National Center's operations.

The current year's research and development activities directly address many of the priorities apparent in the Carl D. Perkins Vocational Education Act of 1984. The National Center in 1986 began or continued work in all twelve major priority areas identified in the Act. With regard to national priorities of concern to target populations (e.g., handicapped, disadvantaged, single parents, limited-English speaking, incarcerated), the National Center is conducting studies in such areas as (1) improving learning in secondary and postsecondary vocational classrooms and laboratories, (2) vocational education programs serving women offenders, (3) entrepreneurship training for non-traditional populations, and (4) an evaluation plan for assessing effectiveness of vocational education programs in serving targeted populations. In anticipation of the priorities apparent in the Act, the National Center has had work underway for several years to enhance basic skill development of students through vocational education programs and to assist youth/adults in the transition from school to work. This year one phase of our activities is designed to capitalize on prior research and development outputs by creating and distributing the materials in a form that will allow teachers and administrators of vocational education programs to meet more fully the needs of their student clientele in these critical areas.

I also want to discuss briefly our various functions:

- Applied Research and Development is concerned with designing programs and materials to assist practitioners in career planning and vocational preparation of individuals who are in school, or who are entering or already participating in the work force. Our R&D function includes five major priority areas of need: special populations, private sector involvement, basic skills, and new technologies. I want to mention two of our many projects as examples:
  - Improving the Learning in Secondary Vocational Classrooms: The purpose of this two-year effort is to collect data that can be used to describe the dynamics of vocational classrooms as a prerequisite to improvement. The project will involve a national sample of 118 secondary schools. Specific objectives are: to identify content and process characteristics that define vocational instruction, to identify the contextual factors that affect vocational instruction, and to describe how instruction in vocational classrooms relates to the learning needs of at-risk students.
  - Basic Skills, School-to-Work Transitions, and Postsecondary and Adult Learners: Three packages will be developed for use by teachers, curriculum officers, employers, and others that will bring together research and development results from the National Center and elsewhere on three key topics. They are: Enhancing Basic Skills through Vocational Education, Youth Transitions from School to Work, and Programs for Postsecondary and Adult Learners. Using our own and other research and development outputs, each package will include an orientation component, a user's implementation guide, and varied printed and mediated materials, such as research summaries,

curriculum guides, instructional materials, teaching strategies, and descriptions/simulations of exemplary practices.

- Leadership Development programs enable vocational educators to deal creatively and effectively with significant issues, problems, and concerns, and to benefit from the latest findings of research and development. A full-time In-residence Program affords opportunities for in-depth individualized study at the National Center, ranging from one week to one year, and the Conference/Workshop Program, conducted at locations throughout the country, provides programs of professional development to thousands of educators and private sector trainers. In 1985, we conducted 106 events in 50 states and the District of Columbia. Eight thousand six hundred eighty state and local leaders from 56 states and territories attended these sessions. Topics included economic development, entrepreneurship, serving the handicapped, and basic skills.
- Dissemination and Utilization is responsible for developing and coordinating a collaborative nationwide dissemination and utilization network to facilitate the use of vocational education research and development products and information in an effort to improve program quality and reduce duplication of effort. In 1985, the National Center responded to over 13,000 requests from various elements of vocational education and the private sector for information and technical assistance. These contacts were received from personal interactions, mail, and telephone, especially our toll-free (800) number. We distributed 426,820 brochures, 312,524 print periodicals, and 64,561 products to teachers, administrators, and private-sector employers. Increasingly, other employment and training agencies, as well as professional associations such as the American Vocational Association,

the American Association of School Administrators, the American Association of Community and Junior Colleges, the National Alliance of Business, the National Federation of Independent Businesses, the National Education Association, and the National Association of Secondary School Principals, are helping to disseminate the output of our research and development activities.

- Information for National Planning and Policy Development includes, for example, needed data on the effects of vocational education as it relates to the experiences of vocational graduates in the labor market. Factors such as participation in the labor market, employment and unemployment rates, and wages and annual earnings are essential to policy development and the ultimate improvement of vocational education. For example, from our various longitudinal studies (High School and Beyond and the National Longitudinal Survey) and other studies, we have data that show: (1) positive relationships between vocational education and labor market outcomes; (2) vocational education provides basic academic skills as well as simply occupational skills; (3) positive effects for vocational graduates in the job market last more than a few years; and (4) general education is the least desirable curriculum for preparing students for work. One of the significant policy questions today is how outcomes differ for students taking vocational education in different institutions, such as comprehensive high schools, area vocational schools, or specialized vocational schools.

- The National Center Clearinghouse builds, maintains, and makes publicly accessible, on-line databases of information about vocational education program improvement projects and curriculum materials funded by the states that greatly reduces duplication of effort and enhances planning/expenditure efficiencies. Among various other projects, this function links the vocational education community through ADVOCNET, an electronic communications network, and publishes abstracts of program improvement projects completed and underway.
- Planning and Evaluation includes working with states, local education agencies, and other public agencies in developing methods of planning and evaluating programs, including the follow-up studies of individuals who complete programs. Increasingly, local school districts of varying sizes are approaching the National Center for assistance in planning and redesigning their vocational education programs. Recent project concerned with time on task in vocational classrooms provide information useful to teachers as they plan how to allot their time. A current project will develop guidelines and practices for assessing the effectiveness of secondary vocational education programs and services for special populations.
- Job Training Partnership (JTPA) Evaluation - After consultation with the National Commission for Employment Policy, the National Center is to report annually to the Congress, the Secretary of Education, and the Secretary of Labor on the extent, efficiency, and effectiveness of joint planning and coordination under this Act and the Job Training Partnership Act. This study, currently underway, will conduct case studies in eight states and a mail and telephone survey of all other states. A report will be issued in March or April 1987.

The National Center has developed a set of sixteen bibliographies dealing with the priorities of the Carl D. Perkins Vocational Education Act. Each lists National Center products that treat the issue as well as additional resources available through the ERIC system. The full set includes 247 National Center products and 107 other items.

Funding Request for Fiscal Year 1987

Consistent with Title IV, National Programs, and Part A, specifically Research, Section 404, The National Center for Research in Vocational Education, P.L. 98-524, we are requesting that the fiscal year 1987 appropriations be at the fiscal year 1986 appropriations level and contain the authorization which includes the forward-funding provision. The Act provides that the National Center be forward-funded through an annual grant, with a funding level of at least $6,000,000.

Congress, in its wisdom, established and has maintained a one-year forward-funding provision for the Carl D. Perkins Vocational Education Act. This provision permits the states and national programs essential lead time to complete planning in accordance with emerging social/economic priorities and to adjust program operations appropriately in relation to known forward-funding levels. Research, development, personnel development, dissemination, and evaluation activities conducted by the National Center require considerable planning time to assure that the design of the activity is sound and the objectives can be realized in the most cost-effective manner. A comprehensive program improvement organization, such as the National Center, needs the benefits of known forward-funding levels to plan its research and development programs and to be able to make tentative commitments with respect to data gathering, pilot sites, demonstration sites, and dissemination and training activities in its efforts to assure full implementation of the research and development outputs.

We request your earnest consideration of continuation of the $6,000,000 forward-funding level in supporting the National Center to carry out the important tasks assigned by the Congress.

Mr. NATCHER. Mr. Stokes, I yield to you.

Mr. STOKES. Thank you very much, Mr. Chairman.

Mr. Chairman, I just wanted to welcome Dr. Taylor before our subcommittee and to say that it is a pleasure to once again listen to his testimony. We are very proud of the work that the Center does: Mr. Chairman, I need not tell you and Mr. Conte that the Center has had some difficulty under the Reagan Administration over the last few years: But, this subcommittee has believed in the vocational education research and program improvement activities conducted by the center. The subcommittee has responded to this institution and has given it an opportunity to continue the work that it is doing.

So, I want to express my appreciation to Dr. Taylor for his testimony here today. I appreciate also the support that you, Mr. Chairman, and Mr. Conte and other Members of this subcommittee have given this Center.

Thank you, Mr. Chairman.

Mr. TAYLOR. Thank you, Congressman. We appreciate it.

Mr. NATCHER. Dr. Taylor, we want to thank both of you. Mr. Hansen, we appreciate your appearance. You have made an excellent statement. Thank you very much.

TUESDAY, APRIL 29, 1986.

EDUCATION PROGRAMS

WITNESS

CECILIA HAM, VICE PRESIDENT, UNITED STATES NATIONAL STUDENT ASSOCIATION

Mr. NATCHER. Ms. Cecilia Ham. We are glad to have you before the committee. We will be pleased to hear from you.

Ms. HAM. Thank you, Mr. Chairman.

Mr. Chairman and Members of the subcommittee, I appreciate this opportunity to appear before you today to present testimony on the fiscal year 1987 appropriations for Title IV student financial assistance programs. I am the elected Vice President of the United States Student Association (USSA) representing students attending over 400 postsecondary institutions—public, private, community and four-year—across the country.

Students are very concerned about their futures. This has been demonstrated through campus events and through the strong student support for our St. Patrick's Day Lobby Day to "Put the Green Back in the Education Budget." An example of activities initiated by student governments is the issue "Critical Times" from the University of Iowa, which I would like to submit for the record. This was sent to students, parents, and the community to alert them to the drastic impact of the administration's fiscal year 1987 budget.

USSA feels that 1986 is the most critical year for the future of student aid programs. The current reauthorization of the Higher Education Act and the passage of Gramm-Rudman-Hollings translates into a climate of major uncertainty for students. This uncertainty and confusion is detrimental for students, whether currently enrolled in high school or college, or persons considering returning to school for retraining. We urge you to quickly appropriate fiscal year 1987 levels to minimize the confusion and reaffirm the support for education as a top national priority.

USSA strongly opposes the administration's fiscal year 1987 budget request to cut $3,200,000,000 from the fiscal year 1986 appropriation level. Funding for student aid comprises less than 1 percent of the Federal budget, yet it was slated to be cut by 27 percent in the administration's proposed budget. These cuts were described by Secretary Bennett in the budget document as "minimal" since Federal education dollars comprise less than 7 percent of total U.S. expenditures for education. This assertion fails to recognize the critical role that these Federal funds have played in funding necessary education programs focused on low and moderate income students during the past 20 years.

The administration's budget request also calls for a major shift in the guaranteed student loan program. The theme of the budget is to transfer a national debt into an overwhelming student debt affecting students choice of majors and careers.

I feel I cannot come and speak before you without remarking on this effort to transfer a national debt into an overwhelming student debt. This will affect the student's choice of majors and careers. For myself, I was fortunate enough to attend an excellent institution, the University of Iowa, and through a combination of my family's support, balancing several jobs simultaneously, university revolving loans and a small GSL, graduated with a relatively small debt burden compared to many of my fellow students.

My intent was to keep my debt burden low even at the loss of having time to devote to my academic studies to enable me to keep my options open. That option for me was to work in the nonprofit arena for issues that I strongly support. I consider myself very fortunate but I am very concerned about the implications of the fiscal year 1987 proposals for students just beginning their education.

The fiscal year 1987 budget proposal for GSL directly threaten the ability of nearly 4,000,000 students to afford to borrow a GSL while also putting into question whether banks will continue to participate in the program. Key parts of the GSL program—the in-school-interest subsidy, the interest rate, and the special allowance to the lender are all threatened under this proposal.

These proposals translate into students paying a much higher interest payments as well as a constant uncertainty as to what one will owe over the repayment period when the costs to a borrower are contingent on T-bill rates when loans are recalculated.

For a student borrowing $2,415 per year for four years—the average according to the Department of Education documents—for a total loan of $9,660 the calculations for repayment under the current law and the proposed budget follow. Out of this loan, only $9,177 would be available for expenses since 5 percent of the loan value is taken out for a "guarantee" fee under the proposed budget and for an origination fee under current law. These amounts must be repaid with interest.

The total amount that must be repaid with interest over a 10-year period under the new proposal is $17,963.89, which is approximately $149.70 per month. This calculation assumes that the current T-bill rate remains constant. Under current law a student borrowing this same amount would pay $13,900.80 with monthly payments of $115.84. Under current law a student is aware of their loan burden at the time they take out the loan, not three to five years later when their interest rate is recalculated.

USSA is very concerned about the current levels of indebtedness because these proposals infuse chaos and uncertainty into an already difficult situation for many students. USSA's major concern is on the funding levels for Title IV student aid programs with a particular concern about the future of Pell grants and TRIO—both slated for massive cuts in the administration's proposal.

To minimize the damaging cuts for academic year 1986-1987, USSA strongly urges the subcommittee to request a supplemental appropriation for $370,000,000. This appropriation would keep over 1,000,000 students from losing some or all of their Pell awards for this fall from the 10 percent cut in available funds. The cut was the result of the 4.3 percent March 1 Gramm-Rudman-Hollings cut and of mis-estimates on the cost of the program by the Department of Education.

At my own campus, the University of Iowa, over 4,000 students receive Pell grants. 1,970 students will lose part or all of their Pell awards under the recently released linear reductions schedule. Of this number, 532 will lose their entire award. At the University of Iowa the dollar loss is $869,306. These cuts are in addition to a reduction to less than one-third of the student's costs being covered by a maximum Pell grant, down from half of the cuts in 1980.

In conclusion, USSA strongly urges the subcommittee to increase the appropriations for student financial assistance programs to reverse the decline in the value of the student dollar on campus. I would ask this subcommittee to appropriate levels for fiscal year 1987 to fund the recently passed House Higher Education Reauthorization Bill, H.R. 3700. This legislation reflects the continued commitment to maintain existing student financial aid programs and in some cases to expand the programs to meet changing demographics and student populations.

The funding for this authorization bill is critical if students are to benefit from the long deliberated changes throughout the reauthorization process. Students have been caught between tuition increases, inflated living costs and real cuts in Federal student aid programs.

USSA is working with students across the country on responses to the budget but we recognize that the key to maintain financial programs for academic year 1986-1987 and 1987-1988 is in the appropriations process. We hope that you will take students' views—the consumers of student financial aid—into consideration in determining both the funding levels and the timeliness of decisions to reaffirm that there is truly a commitment by this nation to funding excellence in education. Your support during the past five years has made the difference for millions of current students.

I thank you for this opportunity to express our position on the fiscal year 1987 appropriation levels for student financial assistance that directly affect students across the country—those students considering entering postsecondary education and those who are trying to complete their education. It is the investment in education today that is a clear investment in our futures.

Mr. NATCHER. Thank you very much, Ms. Ham. You have given us an excellent statement, and we appreciate your appearance.

Ms. HAM. Thank you.

TUESDAY, APRIL 29, 1986.

VOCATIONAL REHABILITATION

WITNESS

MIKE DOSS, CHIPPEWA CREE TRIBE, BOX ELDER, MONTANA

Mr. NATCHER. Our next witness is Dr. Mike Doss. Come around, Dr. Doss.

Dr. DOSS. Good afternoon Mr. Chairman and Members of the committee. My name is Mike Doss. I have been requested to present this testimony on behalf of the Chippewa-Cree Business Committee, Chippewa Cree Tribe, Rocky Boy Reservation, Box Elder, Montana. The testimony concerns House Resolution 4021, a bill to extend and improve the Rehabilitation Act of 1973. I am going to summarize my remarks today.

There are over 400 Indian adults who are eligible to receive vocational rehabilitation services on the Chippewa-Cree Indian reservations. Recent statistics indicate less than 10 percent of eligible participants receive any kind of applicable service from the State that are sufficient enough to train severely handicapped Indian adults for employment and/or vocational educational opportunities. However, with funds approved by this committee, that we appreciate very, very much, received in the rehabilitation grants in 1985, have been utilized to undertake the following projects:

(1) To develop and implement a model handicapped American Indian vocational rehabilitation service project; (2) to train handicapped Indian adults for placement into employment, and/or higher educational opportunities; (3) to place trainees into on-the-job opportunities; and (4) to provide supplemental vocational rehabilitation services formerly not offered by State or local agencies.

This is another very important program to the community. In fact, the Chippewa-Cree Tribe has placed 77 percent of the vocational rehabilitation program trainees within their economic setting; 83 percent of the program trainees are currently attending a work experience training program relevant to the reservation employment needs. It is alarming to understand that the unemployment rate on the reservation last winter was as high as 80 percent, and unfortunately that is a similar condition that exists on other Indian reservations throughout the United States.

I have a list of four prioritized recommendations that I would like to submit at this time with regard to reauthorization of the Rehabilitation Act of 1973:

1. We acknowledge and support the minimum funding of one quarter of 1 percent set aside for American Indian vocational reha-

bilitation programs, which will assure current grantees and new programs funding as indicated by the Education and Labor Committee Report Reauthorization Bill.

2. In the event that H.R. 4021 is not enacted into law before the appropriations committee acts, we recommend the American Indian vocational rehabilitation programs be funded at the 1985 funding level.

3. We request equal protection for Indian vocational rehabilitation projects against the Gramm-Rudman bill similar to the protection that has been granted to State vocational rehabilitation programs.

4. We support vocational rehabilitation amendments of 1986 as presented to U.S. Congress.

I have brought along today a copy of a document that I would like to leave with you, if I might. It is called "Rocky Boys Reservation: A Profile," and it gives a very brief visual and verbal summary of the reservation. I hope that you will have an opportunity to take a look at it. Also, I would like you to know that we are preparing an educational report that we will also be happy to forward to the committee's attention as soon as it has been completed this spring.

I thank you very much, sir.

[The statement of Dr. Doss follows:]

CONGRESSIONAL TESTIMONY PRESENTED TO THE UNITED STATES HOUSE OF REPRESENTATIVES, SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES AND EDUCATION APPROPRIATIONS WITH REGARD TO H.R. 4021, A BILL TO EXTEND AND IMPROVE THE REHABILITATION ACT OF 1973

prepared by:

ROCKY BOY TRIBAL EDUCATION DEPARTMENT
Rocky Boy Indian Reservation
P.O. Box 544
Box Elder, Montana 59521

presented by:

Dr. Michael P. Doss
Arrow Creek Associates

April 29, 1986

Good afternoon Mr. Chairman, and members of the House Subcommittee On Labor, Health and Human Services and Education Appropriations.

/My name is Dr. Michael P. Doss, and I have been requested to present this testimony on behalf of the Chippewa-Cree Business Committee, Chippewa Cree Tribe, Rocky Boy Reservation, Box Elder, Montana./ As requested by the House Subcommittee, I will present a summary of written testimony regarding H.R. 4021, "A Bill to extend and improve the Rehabilitation Act of 1973".

First, I'd like to thank the House Subcommittee on Labor, Health and Human Services and Education Appropriations for allowing me to present testimony on behalf of the Chippewa-Cree Tribe, Rocky Boy Indian Reservation, Box, Elder, Montana.

The Rocky Boy Indian Reservation is the home of the Chippewa-Cree Tribe. The Chippewa and Cree lived in small bands on both sides of the United States and Canadian borders, from the Great Lakes as far west as northern Montana and Saskatchewan, with the Cree generally living further north. A band of Chippewa from Minnesota moved into northern Montana and Canada in the latter part of the 19th century. During the same period, the Cree, led by Chief Little Bear, were in the same area. Having no land base, both bands relocated on the fringes of Montana cities and reservations. They were officially but unsuccessfully deported to Canada through an act of Congress in 1896.

Through the efforts of Chief Rocky Boy, Chief Little Bear, and other prominent non-Indian citizens, the reservation was established on a portion of the Fort Assiniboine Military Reserve in 1916. None of the land has been allotted or sold to individuals, although individual land assignments of 160 acres are made to head-of-households, which are utilized for farm and ranch operations.

The Chippewa-Cree Constitution established by the Chippewa-Cree Business Committee as the governing body for the Tribe. The Business Committee consists of eight (8) members and a Chairman, all of whom are elected on an "at-large" basis for four years. The Business Committee elects a Vice-Chairman and other officers and committees it deems necessary.

The Rocky Boy Reservation is the smallest Indian Reservation in the state of Montana covering an area of 108,015 acres. The reservation lies in the shadows and drainage area of the Bear Paw Mountains of northcentral Montana and includes country of rolling foothills and prairie land. The Rocky Boy Agency is located 26 miles south of the city of Havre, Montana which is a farming and railroad community of approximately 12,000 people. The principal use of lands within the reservation is grazing and dryland farming. There is no light industry or businesses located on the reservation except for small family-owned businesses.

The Rocky Boy Reservation is the poorest Indian reservation in the state of Montana. There are only a few job opportunities offered through the Bureau of Indian Affairs, tribal offices and the public/tribal schools. Of these family heads fortunate enough to obtain a job on the reservation, their annual incomes are far below the national average. Because of the geographic isolation and economic plight, few opportunities exist to keep the people occupied except for the recreation created for theirselves. This recreation consists of church and related activities, stick games, and attending basketball games. Reception for television consists of two stations, neither of which offer educational programs. This extreme isolation, however, probably accounts for the rich cultural heritage continuing on the Rocky Boy Reservation.

I would like to begin my testimony by stating that there are over 400 Indian adults who are eligible to receive Vocational Rehabilitative Services on the Chippewa-Cree Indian Reservation. Recent statistics indicate that less than ten percent (10%) of eligible participants receive any kind of applicable service from the states that are sufficient enough to train severely handicapped Indian adults for employment, and/or, Vocational education opportunities.

Funds received from the Federal Government via the Indian Vocational Rehabilitation Grant in 1985, have been utilized to undertake the following Project: (1) To develop and implement a model Handicapped American Indian Vocational Rehabilitation Service Project; (2) to train Handicapped Indian adults for placement into employment, and/or, higher education opportunities; (3) to place trainees into on-the-job opportunities; and, (4) to provide supplemental Vocational Rehabilitation services formerly not offered by state or local agencies. The "Chippewa-Cree Vocational Rehabilitation Project" is currently funded for thirty-six months from August 1, 1985 to July 31, 1988 by the U.S. Department of Education, and is of critical importance to our Community.

To date, the Chippewa Cree Tribe has placed 77% of the Vocational Rehabilitation Program trainees within their economic setting; 83% of the program trainees are currently attending a work experience training program relevant to the reservation employment needs. In addition, the Chippewa Cree Tribe has guaranteed 75% employment for those trainees successfully completing their training.

The following is a prioritized list of recommendations to the House Subcommittee on Labor, Health and Human Services and Education Appropriations relative to the Reauthorization of the Rehabilitation Act of 1973:

(1) We acknowledge and support the minimum funding of one quarter of 1% set aside for American Indian Vocational Rehabilitation programs, which will assure current grantees and new programs funding as indicated by the Education and Labor Committee Report Reauthorization Bill.

(2) In the event that H.R. 4021 is not enacted into law before the appropriations committee acts, we recommend the American Indian Vocational Rehabilitation Programs be funded at the 1985 funding level.

(3) We request equal protection for Indian Vocational Rehabilitation Projects against the Gramm-Rudman Bill similar to the protection that has been granted to state vocational rehabilitation programs.

(4) We support Vocational Rehabilitation Amendments of 1986 as presented to U.S. Congress.

Mr. Chairman, on behalf of the Chippewa Cree Tribe, I would like to thank you very much for allowing me to testify on their behalf. I am availiable to answer any questions you may have regarding this testimony. If you have any specific questions regarding the Rocky Boy Reservation, the Rocky Boy Tribal Department of Education will respond to these questions in writing and will submit their responses directly to your office for inclusion into the Record.

Respectfully submitted,

Michael P. Doss
Dr. Michael P. Doss, Consultant

4/29/86
April 29, 1986

P. Nagel
Ms. Peggy Nagel, Director

4-29-86
April 29, 1986

Mr. NATCHER. Thank you very much, Dr. Doss. We appreciate your appearance. You have made an excellent statement. Thank you for coming before the committee.

Dr. DOSS. Thank you.

TUESDAY, APRIL 29, 1986.

TITLE XX

WITNESS

CHARLES BAKER, EXECUTIVE DIRECTOR, BUCKHORN KENTUCKY CHILDREN'S CENTER, REPRESENTING CHILD WELFARE LEAGUE OF AMERICA

Mr. NATCHER. Our next witness is Mr. Charles Baker. Come around, Mr. Baker. Mr. Baker, it is a pleasure to have you before our committee. We will be pleased to hear from you at this time.

Mr. BAKER. Thank you, Mr. Chairman. I also have, if you would permit me, Mr. Chairman, two additional pages of testimony that consists of some good information about what happens to these programs in Kentucky, if I can submit those.

[The information follows:]

CHILD WELFARE LEAGUE OF AMERICA, INC.

INFORMATION FROM THE KENTUCKY DEPARTMENT OF SOCIAL SERVICES REGARDING THE RELATIONSHIP OF FEDERAL PROGRAMS TO KENTUCKY'S CHILDREN

Federal funding levels have remained relatively constant since 1972. The lack of a significant increase in funding combined with the high inflation of recent years has restricted program development.

The administrations budget proposal for FY 87 called for restoration of SSBG to FY 85 levels and the elimination of CSBG and WIN which they claim duplicate SSBG functions. While it is correct to note that WIN and SSBG address the self-support goal of SSBG and the earlier Title XX; the funds have not in fact been used for the same purposes. Because of the need to address the often life threatening problems in the areas of abuse and neglect Kentucky has focused available federal and state resources in thoses areas.

In the face of federal and state funding reductions in FY 81 and FY 82, for example, many services such as information and referal, employment related counseling, educational counseling and housing counseling were eliminated as separate services in order to assure funding for protective and juvenile services.

At the same time staffing for the Department for Social Services was reduced from 3015 employees to approximately 2400 employees.

Four years later, in the summer of 1985, a special session of the Kentucky General Assembly partially restored those losses by providing $8.3 million to meet critical needs in child protective services and juvenile treatment services. That action was in response to the report of the Governor's Protective Services Advisory Committee chaired by the Lieutenant Governor. These funds were intended to reduce caseloads from 40 cases per worker to the nationally accepted standard of 25 per worker and provided for an increase in daily payment rates for Foster Care, Private Child care (the state now reimburses 50% of cost) and day care (last increased in 1979).

Please note that this funding was earmarked toward critical needs in the areas of child protective services and juvenile treatment services.

While the 1986 regular session of the General assembly has been able to maintain that level of service, no funds were available to implement additional service improvements recommended by the Protective Services Advisory Committee.

Given this history, the current 4.3% reduction will partially dilute the restoration of services made possible by the Kentucky General Assembly. Further reductions will result in a return to higher case loads and an increase in the number of low income children denied services such as day care.

Kentucky's social service system could not absorb the 500,000+ clients now served by CSBG agencies or the 3,000 adults and 4,000 children now served by the WIN (Work Incentive Program).

HAT SSBG DOES IN KENTUCKY / IMPACT OF 4.3% REDUCTION

SBG funds are used to support the following social service programs:

	PROJECTED CLIENTS BEFORE REDUCTION	CLIENT REDUCTION	TOTAL FUNDING FOR SUBPROGRAM BEFORE REDUCTION	TOTAL FUNDING FOR SSBG SUPPORTED SERVICES BEFORE REDUCTION	TOTAL SSBG BEFORE REDUCTION (STATE FY 87)	REDUCTIO IN SSBG
AMILY AND COMMUNITY SERVICES PROGRAM						
amily Based Services Subprogram including:			$37,361,300	$37,917,400	$14,875,220	$639,600
- Child protective services	40,620	703				
- Homemaker services for families and children	5,880	102				
- Preventive services for families and children	2,267	39				
- Juvenile Services in the Community	12,250	212				
- Staff training						
	61,017	1,056				
lternatives for Children Subprogram including:			$34,816,200	$11,070,400	$6,306,019	$274,600
- Adoptions -- (children placed by agency)	300	7				
- Day care for children (protective services and day care to facilitate parental employment)	7004	174				
- Maternity home services	80	2				
	7384	183				
dult services Subprogram including:			$16,870,400	$7,744,000	$4,427,590	$198,400
- Adult protection and spouse abuse (not including shelter)	8130	200				
- Homemaker for adults	3200	79				
- Alternate care	1950	48				
- Preventive services	5750	141				
		468				
UVENILE TREATMENT SERVICES PROGRAM						
ay treatment	980	19	$2,762,600	$2,762,600	$1,211,239	$52,100
roup Home	310	8	$4,002,000	$4,002,000	$2,361,031	$101,589
esidential (institutional) treatment	810	23	$12,510,400	$12,510,400	$8,403,400	$361,300
GING AND SUPPORT SERVICES PROGRAM						
- Homecare	10645	311	$6,202,100	$6,202,100	$4,265,000	$183,400
	= 81146	2068	$113,821,000	$81,404,900	$41,929,499	$1,082,900

Mr. **Baker**. Mr. Chairman and Members of the subcommittee, I am Charles Baker, the Executive Director of the Presbyterian Child Welfare Agency/Buckhorn Children's Center of Buckhorn, Kentucky. Our agency is a member of the Child Welfare League of America. The League is a membership organization composed of nearly 400 public and voluntary, not-for-profit child welfare agencies throughout the United States and Canada.

The League represents childrens' needs, especially the needs of those who have been abused and neglected, the homeless, the girls and boys in residential care, those in foster care and those in need of adoption. Our agencies and their more than 1,200 affiliates also provide many other services to families and children, including, child day care, care for pregnant teen-agers, day treatment, group home care and homebased care.

My own agency, the Presbyterian Child Welfare Agency, operates the Buckhorn Children's Center, a residential treatment program in Buckhorn, Kentucky, which serves emotionally disturbed adolescents. We also operate a group home in Berea, Kentucky, for older adolescents who are learning the skills of independent living.

In addition, we operate three child development centers in Perry, Breathitt, and Letcher Counties of southeastern Kentucky. These child development centers serve over 90 abused and neglected two-, three- and four-year-olds each day. These three counties, as you know, Mr. Chairman, have some of the highest rates of poverty and unemployment in the nation.

In terms of fiscal year 1986 enacted appropriated funds, Kentucky was to have received a total of $75,800,000 from Title XX social services, Title IV-B child welfare services, WIN, community services block grant, the child abuse prevention and treatment program and a variety of other social services programs. Because of the cuts resulting from Gramm-Rudman-Hollings, this figure was reduced to $72,900,000. In terms of Title XX services alone, this means that 1,200 children in Kentucky will go unserved—over 700 of these children are projected to have been served—from child protective services; that is, services for abused and/or neglected children.

When we hear the dollar figures which flow into Kentucky from the various Federal programs, the numbers are so large they tend not only to the overwhelming but sometimes meaningless: $40,800,000 in Title XX; $3,700,000 in Title IV–B; $4,000,000 in Title IV–E. Let me try to personalize for you the impact of these programs in terms of the lives of two Kentucky children who are affected by them.

When Sammy came to us—and I am not using his real name—he was 14 years old. He had been placed in about 20 different foster homes and several public and private institutions. He came originally from a small eastern Kentucky town where his mother, overwhelmed by her own problems, failed to provide adequate supervision. Sammy wandered the streets and was well known by every store owner and businessman in town. He was an expert at bumming a cigarette here and a quarter there.

When he came to our program we referred to Sammy as "the master of the short-term relationship." He could be absolutely charming for 10 minutes but was terrified of any longer-term relationship—not unnatural for a child who had over 20 different placements in less than four years. All of this was evident in his behavior pattern; he still holds the Buckhorn record for running away 12 times in 10 days.

Sammy had a dozen phobias, but a good relationship, hard work, care specialized treatment and persistence eventually overcame a lot of Sammy's fears. Eventually he overcame his fear of school; he even made a B in albebra.

Today Sammy is 16 years old. About a month ago, he completed the treatment program and moved on, into our Group Home for Independent Living in Berea. Now, in addition to attending shool every day, he has a job on the weekends, in preparation for his economic independence. He has plans to go to college.

The Federal Government has a big investment in Sammy. While he was in the treatment program, it cost about $85 a day to care for him. Thirty-one of those dollars came from a combination of Title IV-E and State funds that we received through our purchase of service contracts with the State. Presbyterians invested the other $54 each day. We think it was worth it.

As I mentioned, Sammy is now in an independent living program, which is designed to help him make the transition into living life on his own. To my knowledge, there are only three such programs now in Kentucky, servicing only 24 children, but hundreds of children go unserved. The newly authorized independent living program, under Title IV-E foster care, can be of tremendous help for girls and boys like Sammny who have no home to go to once they leave our care. We therefore urge this subcommittee to support for the full funding of $45 million for this Title IV-E independent living program.

Billy is a four-year-old who attends one of our child development centers. Billy's mother is mildly mentally retarded and there is no husband at home, which by the way is a completely adequate dwelling without plumbing. Still, Billy's mother is a loving woman who does the best she can. Our job is to help Billy get he best start in life possible by providing him with excellent preschool training and nutritional meals each day. During this winter, one day, the van driver who picks Billy up each morning brought him in and said, "There's something wrong with Billy, he's staggering about, unable to stand and his speech is slurred. I had a hard time keeping him awake."

Our nurse and center director examined him and discovered that Billy was intoxicated. Billy had gotten up that morning and dressed himself, left to catch the bus before his mother awoke. A cruel neighbor had given Billy alcohol before seven o'clock that morning.

The exciting part of the story is that Billy has learned to read this year. He now has a chance to help himself out of that environment and to become a contributing member of society. He will actually start school well ahead of where his mother finished school.

The Title XX social services block grant pays for $11 of the $20 it costs per day to provide Billy with an outstanding preschool program. Presbyterians contribute the other $9.

There are hundreds of other children in Kentucky, like Billy and Sammy, who need help getting through life. If we don't invest the dollars in Billy and Sammy now then we simply will have to invest many thousand more in welfare or perhaps prison payments late. The worst part of this is the waste of human lives. As you have heard, the Presbyterians are interested in the needs of these children and they demonstrate their support and caring through their contributions to help sustain the programs I have just described.

The Federal money we receive from the State of Kentucky to help run these programs helps us to leverage additional money to serve more children and to begin new programs of those children who presently go unserved.

For these reasons, we ask for the continued support of this subcommittee in helping to maintain existing programs and establish new ones. Today I am asking for the support of this subcommittee in funding:

—Title IV-B child welfare services at its fully authorized level of $266,000,000;

—The Title IV-E foster care independent living program at $45,000,000;

—The Title XX social services block grant at $2,700,000,000;

—The child abuse prevention and treatment program at its fully authorized level of $43,000,000; and

—The continuation of the WIN and community services block grant programs at their current level of funding.

Thank you for inviting the Child Welfare League of America to appear before you today. I will now be happy to answer any questions that you may have.

[The statement of Mr. Baker follows:]

CHILD WELFARE LEAGUE OF AMERICA, INC.

TESTIMONY PRESENTED TO THE
SUBCOMMITTEE ON LABOR -HEALTH AND HUMAN SERVICES -EDUCATION
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES
ON BEHALF OF
THE CHILD WELFARE LEAGUE OF AMERICA

BY

CHARLES L. BAKER, EXECUTIVE DIRECTOR
PRESBYTERIAN CHILD WELFARE AGENCY
BUCKHORN CHILDREN'S CENTER
BUCKHORN, KENTUCKY

APRIL 29, 1986

Good Afternoon, Mr. Chairman and members of the Subcommittee. My name is Charles Baker and I am the Executive Director of the Buckhorn Children's Center/ Presbyterian Child Welfare Agency in Buckhorn, Kentucky and I am testifying today on behalf of the Child Welfare League of America (CWLA).

As you may know, CWLA is a national privately supported organization comprised of approximately 400 public and private voluntary not-for-profit member agencies and 1,200 affiliates who provide a variety of child welfare services to children and their families throughout North America. Such services include adoption, foster family care, residential treatment, group homes, day treatment, home-based social services and child day care. Included among our members, for example, are the Massachusetts Department of Social Services; Iowa Children's and Family Services; The Cleveland Christian Home; Child Care Association of Illinois; and the Maryland Department of Human Resources.

My own agency in Buckhorn, Kentucky, provides residential and group care services to children who have been removed from their homes or who face the threat of having to leave their families. Tragically, the reason why many of these children come into our care is because they have been abused or neglected by their parents. Because many of these children suffer from emotional as well as physical abuse, the care we provide extends far beyond basic room and board. It includes counseling and treatment programs to help them develop normally, to realize their self-worth and full capacity as children and ultimately as productive adults in our society.

Our ability to provide these services and to insure the success of these children's lives, begins here -- at the Federal level -- and is very much dependent upon the decisions made by this Subcommittee with regard to funding levels of the programs under your jurisdiction. All of these programs are important to us, but I would like to highlight a few that are especially critical.

Title IV-B Child Welfare Services is essential in helping us keep children and families together. In 1980, P.L. 96-272 amended Title IV-B of the Social Security Act along with the Title IV-E Foster Care Program. At the time these programs were amended, the Federal foster care system was in crisis with approximately 500,000 children nationally reported to be "languishing" in out-of-home care. Many of these children were "lost in the system" with agencies having no idea who they were; where they were; or why they were there in the first place. Many of these children quite literally grew up in foster care, not having seen their families since the day they were first removed from their home. During testimony on P.L. 96-272, Congress learned that one reason for this was that there were few (if any) services available to either prevent the child's removal from the home or to help reunify the child with his or her family once removal had occurred. Child welfare workers had come to view foster care as the only option available to the child during a family crisis.

At that time, Title IV-B Child Welfare Services could be used for maintenance (i.e., room and board) payments for children in foster care. However, P.L. 96-272 amended Title IV-B by requiring that future appropriations could only be used for the purpose of establishing an array of child welfare services designed to: (1) prevent the unnecessary separation of children from their families by assisting in resolving problems and preventing family breakup; (2) reunify the family as quickly as possible when separation was appropriate; and, (3) place children in permanent adoptive homes where restoration to the biological family is not possible or appropriate.

Despite the fact that Title IV-B Child Welfare Services is currently funded far below its authorized level of $266 million (the FY 1986 appropriation level is $207 million; the 1986 Gramm-Rudman level is $198 million) there is evidence that the program is beginning to achieve what Congress intended.

In Maryland, for example, Title IV-B funds were used to develop and implement a Reunification Project. According to a December 1985 report on this project, of the 1,035 eligible children served, 619 or 60% were successfully reunified with their families. The average length of time in care for children reunified through the project was reduced by about two and a half years and estimated foster care costs avoided for the children reunified was $5.4 million. In addition to this project, Maryland has used their Title IV-B funds to: 1) develop parent aide programs designed to intervene into family crisis situations and keep families together; 2) conduct training for child welfare workers to help them evaluate situations where services to the family would be more productive than removing the child; and, 3) develop a foster care review system aimed at effective case planning for children in out-of-home care to ensure them an appropriate and expedient permanent plan.

In Iowa, home-based service programs, utilizing Title IV-B funds, operate in almost every county. In 1985, 2500 families were served by home-based, family-centered agencies who reported a 92% success rate in keeping families together. In addition, almost 200 children who were removed from their homes were successfully reunified with their families as a result of such programs.

The examples we cite here are being replicated all over the country. But much more remains to be done. In Kentucky, for example, a 1985 report from the Governor's Protective Services Advisory Committee titled, Kentucky's Children: A Critical Moment, found that in Kentucky:

> The system for protecting children from abuse and neglect is so inadequate that the state fears for the safety of some children in its care. Some children are being removed from their own homes for lack of services to their families. Some children are suffering from being shifted from one foster home to another and another and another. Some children are growing too old in foster care to have a reasonable hope of being adopted....

These are the very situations which Title IV-B was intended to prevent and which, as has been demonstrated, can be prevented -- but only with adequate resources. Indeed, the Maryland Reunification Project discussed earlier found that the "primary difference between children who have been reunified and those who have not is the extent to which family-focused services were provided in the client's home."

Therefore, in order to enable Title IV-B to be truly effective in addressing the needs of children and families in crisis, the Child Welfare League of America urges this Subcommittee to fund Title IV-B at its fully authorized level of $266 million.

Title IV-E Foster Care and Adoption Assistance are two important programs which provide for out-of-home care for children who are appropriately removed from their own homes and for subsidies for special needs children who cannot be reunited with their families for whom permanent adoptive families are found. Again, in terms of the intent of P.L. 96-272, both programs appear to be working. In 1984, the national foster care population was reduced to approximately 276,000, compared to 502,000 at its peak in 1977. Conversely, the Adoption Assistance program has grown, in a remarkably short period of time, from FY 1982, when permanent adoptive families were found for 3800 special needs children, to FY 1986, when an estimated 21,000 special needs children will be placed in adoptive homes.

The Child Welfare League of America supports and urges this Subcommittee to adopt the Administration's budget request for the Adoption Assistance Program in order that it can provide continued support for special needs children in need of permanent homes.

However, the Child Welfare League of America opposes the Administration's proposal to reduce to $200 million the level of Title IV-B Child Welfare Services appropriations needed to "trigger" an automatic cap on the Title IV-E Foster Care program. The foster care program is currently an open-ended entitlement program, available to children who state agencies determine need to be removed from their homes and who meet several eligibility criteria, one of which is based on Title IV-A Aid to Families with Dependent Children (AFDC) eligibility. These children then are "needy" on several counts: their family's income meets poverty guidelines; they have been determined to be deprived of parental support; and, they are without homes. The Child Welfare League of America strongly urges that the Title IV-E Foster Care Program remain an open-ended entitlement program and urges this Subcommittee to reject the Administration's proposed savings in this program based on any such legislative efforts.

In addition, we would like to call your attention to a program which was recently authorized under the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) as an extension of the existing Title IV-E Foster Care Program -- the Independent Living Program. The authorization provides for $45 million in FY 1987 to enable States to establish transitional independent living programs for adolescents "aging out" of the foster care system. These are children for whom return to home or placement in an adoptive home is not appropriate. Once the federal or state subsidy is terminated, often as early as age 18, these youngsters quite literally have no where to go. Many end up as part of the homeless population, or on public assistance, or worse, as part of the prison population. If funded, this program will provide such transitional services as enabling those eligible participants to seek a high school diploma or its equivalent; making referral to job and vocational training; helping in locating and maintain housing; and providing outreach.

Latest (1984) national estimates are that approximately 50,000 foster care youth, between the ages of 16 and 20, would benefit from this program. The Child Welfare League of America, therefore, strongly urges this Subcommittee to recommend full funding of $45 million for the Title IV-E Foster Care Independent Living Program.

Title XX Social Services Block Grant is the primary source of federal assistance for a variety of social services including, for example, child protective services, intensive home-based services, child day care and respite care. The Administration proposes to fund Title XX at its current (pre-Gramm-Rudman) level of $2.7 billion but with the additional burden of providing needed services now furnished under the Community Services Block Grant (CSBG), the Work Incentive Program (WIN) and Legal Services Corporation (LSC), all of which are proposed for elimination in FY 1987. The Child Welfare League of America strongly opposes the Administration's proposals and adamantly disagreeswith the assumption that the Title XX Social Services Block Grant duplicates the functions of CSBG, WIN or LSC. We are further opposed to the elimination of and urge full funding for these programs, each of which addresses specific and unique problem areas for low-income families and their children.

The Child Welfare League of America further supports the funding of Title XX at $3.3 billion to enable the continuing success of P.L. 96-272, which depends on sufficient Title XX funds to enable States to provide prevention and family reunification services. Additionally, if families are to stay together and be self-sufficient, there is an urgent need for more Title XX funds to halt the present trend in many states of withdrawing public funding for day care for children in poor working families and as supportive services for families where child abuse and neglect has occurred.

Adoption Opportunities (Title II of the Child Abuse Prevention and Treatment Act) is a program which provides funding to support activities aimed at eliminating barriers for the adoption of special needs children. Funds are provided through the discretionary grant process for activities which generally support systematic efforts. An example of such efforts include: the funding state-wide training activities aimed at recruiting minority homes for special needs minority children who are legally free and waiting for permanent homes. In addition, the Adoption Opportunities Program funds the National Adoption Exchange which provides a national photo-listing service of children who are available and waiting to be placed in order that permanent families might be identified for such children.

The Administration proposes to fund this program at $1.4 million in FY 1987, far below its authorized level of $5 million. In FY 1986, this Subcommittee approved the fully authorized level of funding for this program in order that targeted efforts might be made to find homes for special needs minority children. Because the Administration proposed rescinding $3.4 million of the enacted FY 1986 appropriated funds, those monies have not yet been spent and many children still remain waiting for permanent homes. According to recent HHS figures, approximately 36,000 special needs children are available and waiting to be placed in adoptive homes. Of this number 42% are minority, 37% are handicapped. The median age is 12 and 68% have been in foster care for 2 or more years.

The Child Welfare League of America strongly believes that the FY 1986 appropriation of $5 million is necessary along with the fully authorized level of $5 million in FY 1987 in order that permanent homes be found for all of the 36,000 waiting special needs children.

The Child Abuse Prevention and Treatment Act (P.L. 93-247) provides financial assistance for demonstration programs in the prevention and treatment of child abuse and neglect as well as grants to State for the purpose of developing and implementing child abuse and neglect prevention and treatment programs. The Administration has proposed consolidating this program with two other programs: the Family Violence Program and the Federal Challenge Grant/Children's Trust Fund Program, at $30.5 million -- far below the combined FY 1987 authorized levels for these programs.

The Child Welfare League of America strongly opposes the Administration's proposal to consolidate the Child Abuse Prevention and Treatment Act and urges this Subcommittee not only to reject this proposal but to strengthen this program by funding it at its authorized level of $43 million.

The need for strengthening this program is underscored by a recent Child Welfare League report titled, "Too Young To Run" which found that from 1983 to 1984, reports of child abuse and neglect increased by 16% nationally and reports of child sexual abuse increased by 59%. Furthermore, as these reports increased, resources such as staff and services, either declined or stayed at the same level. As a result, States were forced to prioritize child abuse and neglect reports based on administrative needs rather than the needs of children. For example: neglect reports now receive a lower priority (despite the fact that neglect accounts for the largest number of fatalities); reports of older children, often defined as young as 11, are having to wait sometimes up to two weeks for investigation; and, many cases which could be more appropriately treated in the home result in out-of-home placement, due to the lack of home-based support services. The needs of children must not continue to be given second priority to administrative needs. We, therefore, urge the full funding of the Child Abuse Prevention and Treatment Act.

There are many other important programs for children that deserve attention but which time does not allow us to detail. However, in brief:

The Child Welfare League of America urges this Subcommittee to reject the Administration's proposal to consolidate the Family Planning and Population Research Act (Title X of the Public Health Services Act) along with three other health programs into a Primary Health Care Block Grant. CWLA recommends the continuation of this as a categorical program at the full authorized level of $170 million for FY 1987. Studies have shown that each dollar spent for family planning is estimated to yield a minimum saving of two dollars in health and welfare costs incurred as a result of unintended pregnancies. These savings are even greater among teens, estimated to be about three dollars saved for every dollar spent on preventive family planning, due to the fact that teenage pregnancy and childbearing are typically problematical medically and teen parents are more likely to need public assistance of some form.

The Child Welfare League of America urges this Subcommittee to reject the Administration's proposal to fund State grants for the Education For All Handicapped Children Program (P.L. 94-142) by $80 million below the enacted FY 1986 appropriated level. CWLA recommends a funding level of $1.45 billion for the basic State Grant Program in in FY 1987. Despite an overall drop in school enrollment, handicapped children needing services are increasing by 40,000 a year. Without adequate Federal support, local school districts are reluctant to incur higher costs for special education services and are prevented from improving and maintaining existing service needs. Funding at $1.45 billion would raise the per pupil expenditure from 10% in FY 1986 to 12% in FY 1987 and maintain the most basic services to our most vulnerable children.

The Child Welfare League of America recommends that this Subcommittee reject the Administration's proposal to decrease funding for Head Start by $11 million below enacted FY 1986 appropriated levels, which would result in a funding level possibly lower than the FY 1985 level. CWLA recommends an appropriation of $1.22 billion for FY 1987 which would allow for a modest growth in the number of children served. Currently, Head Start serves only one of five eligible children; yet, it has proven to be one of our most important tools in breaking the cycle of poverty. According to the 1984 High Scope Foundation research, twenty years later, children who participated in Head Start evidenced fewer high school drop-outs; more high school graduates; fewer births out of wedlock; lower unemployment; and, higher incomes than similar individuals who did not participate.

The Child Welfare League of America urges this Subcommittee to reject the Administration's proposal to consolidate the Family Violence Program (Title III of the Child Abuse Prevention and Treatment Act) and the Federal Challenge Grant Program into a new Family Crisis and Protective Services Program. Both programs have specific authorities targeting distinct populations who are victims of abuse. CWLA believes that The Family Violence Program should be funded at $12 million in

FY 1987 and should remain targeted on family violence, given that 2 million women per year are reported as battered and that 20% of the visits to emergency rooms are made by victims of spousal abuse. This has resulted in an increased need for a system of emergency shelters and prevention and counseling services, none of which would be specifically required under the Administration's consolidation proposal. The Federal Challenge Grant Program/Children's Trust Fund is a program which encourages States to develop their own funding mechanism for child abuse prevention activities, a critical element in reducing overall levels of child abuse and neglect. Since 1980, 34 States have enacted Children's Trust Funds which helped free up funds for the provision of treatment services. CWLA recommends the continuation of this categorical program at $5 million for FY 1987.

For these programs and others, on behalf of America's children, we need more, not less investment. We appreciate this Subcommittee's past support of these programs, especially over the last several years, and look forward your continuing support.

Mr. NATCHER. Thank you very much, Mr. Baker. You have made an excellent statement and we appreciate your appearance before the committee. You come back and see us.

TUESDAY, APRIL 29, 1986.

HEAD START, CHILD WELFARE SERVICES

WITNESS

HELEN BLANK, GOVERNMENT AFFAIRS, CHILDREN'S DEFENSE FUND

Mr. NATCHER. Our next witness is Ms. Helen Blank. Come around, Ms. Blank. You have been patient. The last shall be first.

Ms. BLANK. I hope I am not the very last.

Mr. NATCHER. You are the very last, and we are delighted to have you before the committee

Ms. BLANK. We appreciate the time you took to go out and support the Head Start Reauthorization Bill. It was worth waiting to get that important bill reauthorized.

The Children's Defense Fund (CDF) welcomes the opportunity to testify on fiscal year 1987 funding levels for Federal programs serving low-income children and families. CDF appreciates the subcommittee's strong support on behalf of the Nation's children.

American families and their children are in trouble. The median income for all families with children is lower now than it was in the 1970s. Most tragic, more and more families are classified by their own government as officially poor. Not only have the numbers of families with children in poverty increased, but the poor have become poorer.

Thirteen million of America's children now live in poverty, and in 1983 42.2 percent of them lived in families with incomes below one half of the poverty line. Child poverty has multiple causes. Children are poor because of economic downturn and depression-level parental unemployment. Recovery has done little to lift up the more than 3,000,000 children who were added to the official poverty roles between 1979 and 1982.

Children are increasingly poor even if their parents are fortunate enough to find employment. For employment is no longer a guarantee against poverty in America. More and more parents are struggling to support their children through work— yet low wages and reduced government support keep them in poverty.

The plight of the working poor has worsened significantly. Benefits and assistance have been withdrawn from the working poor under Medicaid, AFDC, food stamps, and child nutrition programs. Few low paying jobs provide basic health insurance coverage or other benefits for workers or their children. The failure to adjust the minimum wage even for inflation since 1981 prevents many working parents from earning enough to escape poverty.

A full-time minimum wage job in 1986 pays $6700— 75 percent of the poverty level for a family of three. Another obstacle in the path to self-sufficiency for low-income working families has been the large and growing Federal tax burden imposed on them since 1980. A family of four earning poverty-level wages in 1986 will pay between 10 percent and 12 percent of its income in Federal taxes alone.

Children are also poor because of changing family demographics, particularly the growth of female-headed families. Since 1975, the number of children living in female-headed families has increased 20 percent. Today, one in five of all children lives in a single-parent, female-headed household. Over half of them are poor.

Finally, and most tragically, children are poor because of declining support from their Federal Government. Since 1980, $10 billion has been taken from poor children. The decline of Federal assistance not only crippled the efforts of families to struggle back out of poverty, but it made living in poverty an even harsher existence for 13,000,000 children.

We believe that wise investment in our Nation's children is the best investment for our Nation's future. A strategy for investment in children must be guided by principles of prevention and cost-effectiveness as well as compassion, and it must be directed to the development of healthy, educated children, self-sufficient youth as well as strong families. Such a strategy requires:

1. No further budget cuts in Federal programs vital to the survival of poor children and families; and

2. Selective new investments to combat epidemic child and family poverty and promote economic growth and development toward self-sufficiency.

A new investment policy in children and youth is not only a moral imperative, it is a practical necessity. Children are the country's future workers and taxpayers, its future leaders, artists, teachers and scientists. All Americans have a stake in our younger generation.

We no longer have any margin for human neglect. While in 1950, there were 17 workers for each retiree, by 1992 that ratio will have shrunk dramatically— to three workers for each retiree. One out of every three workers will be from a racial minority and at least one out of every four will have lived in poverty.

Wise investment in that-effective, preventive program for children is also sound economic policy in a time of budgetary crisis. Study after study document the savings generated from investments in prevention. Every dollar invested in comprehensive prenatal care, for example, saves over $3 in reduced health care costs in the first year alone of an infant's life. That same dollar saves up to $11 in total medical expenses over the lifetime of the child. Every dollar invested in Head Start returns $7 in reduced public expenditures and increased public receipts by program participants.

Years of research also provide the success of many critical children's programs— they not only work, but work well:

—Poor children enrolled in Head Start, for example, score better on standardized tests than their peers; achieve more in school; are less likely to be absent, fail a grade, drop out of school, or need special education classes; and are more likely to finish high school, continue education beyond high school, and be employed.

—Prenatal care programs under WIC, Medicaid, and the maternal and child health block grant increase birthweight of infants, reduce premature births, and reduce neontal infant mortality. Yet the number of women receiving late or so prenatal care is increasing.

—Compensatory education programs eliminated 40 percent of the gap between black and white elementary school children in the 1970s, despite serving fewer than half of those in need. Studies show that Chapter I students consistently gain more in reading and math skills than children not participating and that these gains continue after participation ends.

This committee, through expanding support for several key programs, can take critical steps toward a policy of sound preventive investment.

Head Start: We recommend an increase of $150,000,000 in Head Start above its fiscal year 1986 funding level of $1.087,000,000. This would allow an additional 60,000 children to receive a Head Start experience.

The role that an early childhood development program can play in promoting a child's development has impressed a broad range of policymakers. For example, the Research and Policy Committee of the business-led Committee for Economic Development strongly supports a public investment in such programs for low-income children.

Recognizing the importance of making this early investment, more and more Americans are also enrolling their children in early childhood development programs. Enrollment of three- and four-year-olds nearly doubled from 1970 to 1983. Fifty-three percent of these three- to four-year-olds whose families had incomes of $25,000 a year or more attended preschool program in 1982.

But not all American children are benefiting equally from this trend. Fewer than 29 percent of such children whose families had incomes of less than $10,000 a year were enrolled that same year. Most poor children are not getting an equal opportunity to participate in early childhood development programs.

Head Start is the primary source of support for comprehensive early childhood development programs for low-income children. It currently reaches 448,000 children; only 16 percent of those who need its services.

Head Start works for children. Children in Head Start obtain markedly higher levels of health care than children not in the program, have fewer absences from school, and perform better on physical tests. In the program year 1983-1984, 100 percent of the children enrolled for 90 days or more completed medical screening, including all of the appropriate tests. Ninety-six percent of those identified as needing treatment received treatment. Ninety-five percent of the children were brought up to date in their immunizations.

Head Start also works for parents. Four out of five of Head Start children's parents are providing a volunteer service in the program. Thirty-one percent of the program's paid staff are parents of current or former Head Start children.

Head Start's multi-faceted approach is key to helping low-income children and their families. The reasons are not mysterious. Children who miss breakfast and have little to eat during the rest of the day will have a difficult time concentrating in school, and generally will fail to thrive. Children who are sick and who do not receive regular health care will miss too many days of preschool, will be lethargic when they do attend, and will suffer from these problems as they continue their school careers.

With special help, parents who are trapped in a cycle of poverty and deprivation can become partners in their children's learning experiences and take steps toward self-sufficiency themselves. Communities that are involved in helping themselves and running their own programs can become stronger.

In some States, the education reform movement has spawned interest in State-funded preschool programs. However, the large majority of States do not provide funds for early childhood development programs for four-year-olds. In a number of States such as Mississippi, which is only now appropriating funds for kindergarten programs for five-year-olds, State funding for preschool does not seem to be a realistic option in the near future. Alabama just won a difficult battle to prevent the total elimination of child care assistance for low-income children.

In this context, an expanded Federal commitment to Head Start is essential to ensure that needy children in every region of the country have access to an effective early childhood development program.

Maternal and Child Health Block Grant: CDF recommends a funding level of $553,000,000 for the MCH block grant for fiscal year 1987. This includes an additional of $75,000,000 above funding levels of the past two years. The additional funds would be used to reach greater numbers of low-income pregnant women with prenatal care services and to target specialized comprehensive health programs for particularly hard-to-reach old children.

Study after study has demonstrated the cost-effectiveness of investments in maternal and child health:

—It costs $600 to provide a mother comprehensive prenatal care and thus grow healthy babies; it costs more than $1,000 per day to keep low birthweight babies alive through neontal intensive care.

—It costs $25 to provide a child with treatment for strep throat under Medicaid, it averages $600 per day to hospital a child for untreated illness.

At the same time, there is widespread evidence that key maternal and child health indicators have eroded in the face of increased poverty and program cutbacks.

—Between 1982 and 1983, postneonatal mortality (deaths of infants ages 28 days to one year) rose 3 percent nationwide and 5 percent nationwide for black infants. The mortality increase among black babies was the first such recorded increase in 18 years. The black/white infant mortality "gap" in 1983 was the widest that it has been in over 40 years.

—In 1983, the percentage of women receiving late or no prenatal care rose for the third consecutive year. The percentage of premature and low birthweight births also rose in 1983.

—Reports from around the Nation indicate that anywhere from 65 percent to 80 percent of school-aged children are suffering from one or more untreated health conditions.

Immunization: CDF recommends adding an additional $25,000,000 to the childhood immunization program in order to purchase a complete immunization service for an additional half million infants, toddlers, and preschoolers.

—The current immunization program contains enough funds to finance a full series of immunizations (including pertussis, tetanus, diphtheria, measles, mumps, rubella, polio, and mennigitis) for about 1,000,000 children per year. Yet there are 21,300,000 children in the United States below age six. Nearly one in five—about 5,000,000—is poor.

Despite the many poor children who lack proper immunizations, the childhood immunization program is funded at a level of only $57,000,000.

—Each dollar spent to immunize saves in reduced illness and hospitalization costs, according to the Center for Disease Control. It costs $47 for a complete immunization series for a child (includes DPT—diptheria, pertussis, and tetanus; measles; mumps, rubella; polio; and meningitis). It costs an estimated $25,000 per year to keep a mentally retarded child in an institution. The Nation saved an estimated $1,000,000,000 in the first decade of measles immunization efforts. It is bad fiscal policy to have less than half of black preschoolers fully immunized.

Children with Special Needs: We also urge you to take steps to help improve services for three vulnerable groups of children with special needs: victims of abuse and neglect, children with serious emotional problems and children in foster care. By increasing funds for the child welfare services program, the child and adolescent service system program, and the Title IV-E foster care and adoption assistance programs you can help to more appropriately address the service demands created by escalating reports of abuse and neglect, and increasing gaps in services for emotionally disturbed children and adolescents.

Specifically, we request funding the child welfare services program at $220,000,000 for fiscal year 1987 ($22,000,000 over the post-Gramm-Rudman level and $13,000,000 over the approved fiscal year 1986 level) and the child and adolescent service system program at $6,200,000 ($1,600,000 over the approved fiscal year 1986 level).

Since 1981, reports of abuse and neglect of children have increased by 40 percent, reaching 1,700,000 million children in 1984, an increase of 16 percent from 1983. Yet the staff and services needed to respond to these troubled children and their families have declined significantly in many States.

—In a September 1985 report on foster care entry rates, the Inspector General of the U.S. Department of Health and Human Services noted that increasing reports of abuse in the States studied had not been matched by increased resources, and that "to respond to this increased workload, workers must carry loads more than that considered acceptable to do a good job."

—A report by the Governor's Protective Services Advisory Committee in Kentucky noted that while child abuse and neglect reports more than doubled from 1980 to 1984 (from 15,668 to 32,713), services and staff were cut dramatically. The responsible agency lost more than $13 million in Federal Title XX funds and an additional $5,000,000. in State social service dollars. One hundred forty-one social work positions and 152 professional positions were cut.

Increased funding for the child welfare services program will enable States to better respond to these increasing reports, and to continue to provide services to keep families together where possible, eliminating the need for unnecessary and costly foster care.

Increased funding for the child and adolescent service system program (CASSP) will help States continue to improve the coordination of services to seriously emotionally disturbed children and adolescents. Currently fewer than one in three of these 3,000,000 seriously disturbed children is receiving the help they need. Too frequently these youth fall through the cracks of the various child-serving systems.

In spite of such need, the administration proposed for the third year in a row to eliminate CASSP in fiscal year 1987, beginning with a significant rescission in fiscal year 1986. In so doing, the administration takes away grants to 22 States (Alabama, Arkansas, Delaware, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Mississippi, New Jersey, New York, New York, Ohio, Oklahoma, Pennsylvania, Tennessee, Vermont, and Wisconsin) that have stimulated state-level progress in facilitating agency coordination on behalf of these youth.

An investment on behalf of these children now will prevent expenditures in the future. It's not a question of whether to invest in their behalf, but when and how.

The increased funds for abused and neglected chldren and those with serious emotional problems are seriously needed to complement funds targeted on youth in out-of-home care. Under the Federal foster care and adoption assistance program authorized under Title IV-E of the Social Security Act, certain children are entitled to foster care payments, as well as to adoption assistance payments. An extension of assistance to IV-E children involved in the recently enacted Consolidated Omnibus Reconciliation Act provides $45,000,000 to the States in fiscal year 1987 and again in fiscal year 1988 to assist older youth in foster care who cannot be returned home or adopted in their transition to independent living.

Without such assistance, these children too often are discharged to their own care at age 18 and then move into homeless shelters or on to public assistance rolls where they continue at public expense. Approximately 40 percent of the approximately 300,000 children in foster care today are adolescents.

Chapter I: As an important early intervention to prevent disadvantaged children from falling behind or dropping out of school, we strongly urge an increase of $200,000,000 in fiscal year 1987 funding for the Chapter I compensatory education program. Chapter I provides essential support to school districts with large numbers of low-income students and is targeted for remedial and compensatory education services.

Despite the proven effectiveness of the Chapter I program, access to these compensatory education services has been dramatically reduced during the past five years: in 1984, only Chapter I programs reached only 52 students for every 100 poor school-aged children, compared to 75 per such 100 children in 1979. An increase in fiscal year 1987 funding to $3,890,000,000 would begin to reserve this alarming decline and enable school districts to expand compensatory education services to middle school students at risk of becoming high school dropouts.

Youth Employment: We urge the committee to respond to the serious and continuing shortage of opportunities for work and learning among poor and minority teen-agers by increasing fiscal year 1987 appropriations for Job Corps and the summer youth employment program. Youth unemployment rate in our major urban areas remain frighteningly high, typically exceeding 40 percent, and the number of teen-agers now employed is actually lower than it was at the depths of the 1981–1982 recession.

In order to reach more disadvantaged youth with intensive, cost-effective training services and to strengthen remedial education activities within summer jobs programs, recommend fiscal year 1987 appropriations of $740,000,000 for Job Corps and $765,000,000 for the summer youth employment program.

Work Incentive Program: The Work Incentive Program (WIN) remains the primary source of Federal support for employment and training programs which move welfare recipients toward permanent jobs and self-sufficiency. States are increasingly utilizing WIN funds in innovative and effective ways, designing comprehensive programs which appear successful in removing barriers to employment and reducing reliance upon AFDC for income support.

Given the Federal Government's direct interest in and responsibility for efforts to promote economic self-sufficiency, we urge the committee to continue WIN funding for fiscal year 1987 at its fiscal year 1986 level of $220,000,000.

School-Aged Child Care and Resource and Referral Programs: We recommend $10,000,000 for fiscal year 1987 to help communities start school-age child care and resource and referral programs. A modest amount of funds in this area could encourage States to expand their commitment to these important services.

Mr. **Natcher**. Thank you very much, Ms. Blank. You made an excellent statement and we appreciate your appearance before the committee.

At this point in the record we will insert the statement of Dr. Laurie Garduque of the American Educational Research Association.

[The statement of Ms. Garduque follows:]

American Educational
Research Association

Testimony Presented on Behalf of the

American Educational Research Association

by

Laurie Garduque, Ph.D., Director
Governmental and Professional Liaison
American Educational Research Association

to the

United States House of Representatives
Appropriations Subcommittee on Labor, HHS, and Education

In Support of the

Office of Educational Research and Improvement

Tuesday, April 29, 1986
3:50 p.m.

1230 SEVENTEENTH STREET, N.W., WASHINGTON, D.C. 20036 (202) 223-9485

Mr. Chairman and Members of the Subcommittee, I am Laurie Garduque, Director of Governmental and Professional Liaison for the American Educational Research Association. On behalf of AERA I want to thank you for this opportunity to present our views on the FY 87 appropriation for the research, statistics, and improvement activities of the Department of Education.

AERA is the most prominent professional organization of individuals concerned about educational research and its application. My comments will focus on the agency charged with carrying out the Federal role in conducting and supporting research and statistics, the Office of Educational Research and Improvement, its ability to carry out its mission, and its future. AERA urges you and Members of the Subcommittee to grant the Administration's request for a $12 million increase over last year's funding and provide OERI with $70 million for research and statistics. We also ask for your assistance in assuring that OERI meet the highest standards of research and scholarship in carrying out its activities. Finally, I want to underscore the importance of educational research and development in improving the quality of American education.

Reorganization and Reauthorization of Research and Statistics

As you know, Secretary of Education Bennett reorganized the programs and activities of OERI last fall. Under the Secretary's plan, the National Institute of Education and the National Center for Education Statistics ceased to exist as discrete units. Five program units have taken their place: Office of Research, Center for Statistics, Programs for the Improvement of Practice, Information Services, and Library Programs. At the end of this fiscal year, the authority for research under Section 405 of the General Education Provisions Act expires.

Both the Senate and the House education committees have proposed reauthorization legislation. Before I discuss the Department's new alignment and structuring of activities, I want to make a few observations about educational research's progress and prospects.

Educational research has made great strides in the past dozen years, progress due in no small measure to the leadership of the federal government, especially NIE. Advances in educational research include new strategies and methodologies for the study of education, the accumulation of new knowledge in key areas of study, and the ability to put research to effective use. It is not difficult to trace these developments to the direct involvement and support of NIE.

Since NIE was created in 1972, Congress has supported the concept of improving education through research but has often seemed skeptical about the possible results. Their ambivalence toward education research is evident in NIE's funding history. The early trials and tribulations of the agency need not be repeated here. NIE never realized its ambition to become an agency which might, like the National Science Foundation and National Institutes of Health, command sufficient resources to undertake a sustained and comprehensive research program addressing all of the principle issues of education in our society. Still, the agency successfully managed its meager resources to develop productive lines of research in several areas, including studies on the acquisition of reading, writing, and mathematics skills; testing and assessment; teaching and classroom management; school finance and improvement of governance and school effectiveness. In addition, the agency successfully completed Congressionally mandated studies of compensatory education, violence in the schools, and vocational education. It also redesigned and improved the National Assessment of Educational Progress.

It has become clear that educational research can produce answers and is ready to assume a necessary and more prominent role in the future progress of education. The many impressive national and state reports on educational reform and improvement of the past three years rely extensively upon the information, knowledge, and perspective gained through research. Last year, the House Subcommittee on Select Education held hearings on the reauthorization of the research and statistics functions. Witnesses representing state legislatures, state and local education officials, and classroom teachers presented testimony on the need to protect and preserve the federal role in the conduct and support of education research. It is time to put NIE's troubled history behind us and consider ways in which the research functions might be strengthened and improved.

From this perspective, the Administration's reorganization of OERI should be judged by whether the new arrangement will improve the effectiveness and impact of the research and statistics functions. AERA has endorsed the broad outlines of the Secretary's plan and feels that it represents a substantial improvement over the previous structure. We are encouraged by the quality of the personnel appointed to head OERI's principal operating units. AERA believes that both in general and with respect to the administrative provisions for various activities, the Department's reorganization is appropriate. We are pleased that H.R. 2246, the Education Research and Statistics Amendments of 1986, provides for the reauthorization of research, statistics, and improvement activities to reflect the current organization.

OERI's FY 87 Budget Request

The Administration's FY 87 budget request would bring to a halt the precipitous decline in the quantity and quality of information on the condition of education. According to a recent GAO report, fiscal resources for producing statistical information have fallen by over thirty percent in real terms in the last five years. During the same period, education research experienced over a fifty percent reduction in support. The GAO report shows the reductions for education information have been substantially greater than the ten percent loss experienced by education as a whole. The loss of $24 million in current dollars is not a very large sum over five years, in terms of either the Department's or the entire Federal budget. Afterall, the federal investment in education research and statistics represents less than one half of one percent of the Department of Education's total budget. But as proportions of the operating budgets for agencies producing information on the condition of education, the reductions have been quite dramatic.

Given the present state of information on the condition of education, AERA believes the Administration's budget request is basically sound. Over ninety percent of the budget would go toward the maintenance of current activities. The increase would be directed toward areas in greatest need of attention: namely, repairing the data base and providing support for field initiated research.

The budget increase would enable the agency to make much needed improvements in statistics and information gathering activities. As part of the effort to redesign the Center of Statistics data collection program, OERI solicited comments from educators, policymakers, and researchers. The Center's program was criticized for its lack of comprehensiveness, integration, accuracy, comparability, and timeliness. One example illustrating these problems is information on teachers. Although major teacher shortages are projected by the year 1990, the last time relevant data on turnover and attrition were collected was 1969. The Center's data base has been found inadequate to address questions about how school policies affect people's decision to enter and leave the profession, or how merit pay or master teacher plans affect the quality of teaching. The gaps in information make it possible to assess the number of math and science teachers or the seriousness of the decline in minorities entering the teaching profession. OERI has planned several initiatives in response to those criticisms. But efforts hinge on the availability of funds.

The major casualty of the cost cutting moves instituted in research has been independent research by individual investigators. Budget cuts have virtually eliminated support for grants competitions for field initiated studies by individual researchers and unsolicited proposals. The Administration's budget request includes $5 million for new research projects. The increased funding would help to restore the balance in the federal government's investment in educational Research and Development. Institutional program awards comprised over 90 percent of the research budget in FY 86 as compared to 67 percent in FY 81. Without additional funds, OERI has an extremely limited capacity to respond to creative and innovative ideas from the field, to stimulate research in areas of critical need, or to foster interesting possibilities for interdisciplinary research.

Overall, AERA supports the Administration's budget request and believes the increases are appropriately targeted. We believe OERI's reorganization has improved and strengthened the administration and management of research and related activities. OERI recently completed a national competition for regional laboratories and centers, winning high praise from the research community in the process. We ask for your continued support of OERI's efforts to maintain high standards for research and scholarship. We are concerned about the Department-wide directive to limit the use of peer review in making decisions about the allocation of resources. Peer review is absolutely critical to preserve and protect the independence and integrity of the research and statistics functions.

The budget request would provide continued support for institutional programs including regional laboratories and national research centers, NAEP, and the Educational Resources Information Center (ERIC) system. The laboratories and centers constitute the centerpiece of OERI's operation and stable and continued support is absolutely essential to their success. Their funding represents the major share of the federal investment in improving the quality of education through research and its application.

New initiatives would significantly enhance the Department's capacity to produce information of high quality and make it available, now and in the near future. There is a need now more than ever for an enhanced research and development capacity. All across the country, state and local governments have mounted major initiatives to improve the quality of education. Blue ribbon commissions, task forces, governors, state legislators, state and local school officials, teachers, and parents are analyzing the problems confronting American education and seeking the information and knowledge gained through research. They realize that education is too important an enterprise to leave policy decisions to chance.

AERA urges you to support the Administration's budget request. With state and local education agencies assuming an ever increasing share of the costs of education, they have neither the resources nor the capability to support education research, statistics, and development. Only the federal government has the resources and span of interest to conduct research of national scope and concern.

American education cannot afford further erosion of the federal government's capacity to produce information on the condition of education. It is understandable that in this period of fiscal duress, pressures to reduce the deficit overshadow consideration of expanding resources. On the other hand, information on the condition of education could play an important role in decisions about deficit reduction measures.

The GAO report mentioned earlier gives us a preview of what our diminished capacity to produce information could bring. Declining resources for research will lead to fewer awards as well as smaller awards. These reductions will probably narrow the scope of research questions or lead to the neglect of some topics altogether. The costs of leaving our statistics and information gathering activities in disarray means both information lost and policies based on something less than the most complete, relevant, and timely data.

Our nation's children have a right to an education based on the soundest information available and supported by the latest advances in science and technology. AERA seeks your continued support for the federal role in education research, statistics, and improvement activities.

Thank you again for this opportunity to share our views with you. We would be pleased to answer any questions you or members of the committee may have.

Mr. NATCHER. We will now adjourn until 10 o'clock in the morning.

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